Medical Malpractice: State-by-State Analysis — page 12

Health Care News

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Md. Single-Payer Proposal Would Cost 117,000 Jobs, Shrink Payroll Tax Receipts by $4.89 Billion

Universal health care propsals would have "negative economic consequences for the state, including decreases in employment and payroll"

BY CONRAD F. MEIER

A proposal to implement single-payer health care in Maryland could cost the state as many as 117,000 jobs and as much as $4.89 billion in lost payroll tax receipts, according to a study jointly released last November by The Heritage Foundation and the Maryland Foundation for Research and Economic Education (Maryland FREE).

The report, prepared by analysts at the Boston-based Beacon Hill Institute (BHI), considers the economic implications of four universal health care proposals legislators are expected to consider during the 2002 General Assembly session.

"Universal Health Care and the Maryland Economy" relies on the State Tax Analysis Modeling Project (STAMP), which measures the effects of public policy changes by applying statistical and econometric methods to data collected specifically for the state or locality being studied.

BHI analysts have applied the STAMP model in 13 other states to identify and measure the consequences of changes in health care policy, tax policy, and other public policy variables.

The report stresses to policymakers the importance of taking into account the economic costs associated with implementation of a universal health care system. Such costs are an "inevitable byproduct of the increases in tax rates or employer costs that [universal health care's] implementation would necessitate."

All of the universal health care proposals, according to the analysis, would have "negative economic consequences for the state, including decreases in employment and payroll." The pro-

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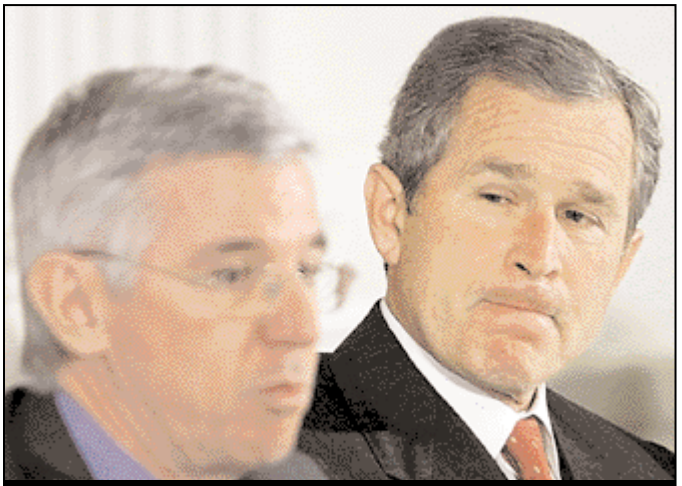

President George W. Bush (R) listens to Maryland Governor Parris Glendening during the National Governors' Association meeting in the East Room of the White House last February. Photo/Tim Sloan

Emergency Health Powers Proposal: ***A Poison Pill***

BY DR. MICHAEL A. GLUECK AND DR. ROBERT J. CIHAK

And so it came to pass, in the fall of 2001, that the federal government, having taken unto itself great new powers to fight terrorists, turned its attention to the rest of us.

Specifically, Congress has proposed an emergency health powers law that would give state governors wide-ranging new powers, including authority to compel mass vaccination; to ration medical care; to confiscate and operate private medical facilities; and to seize and destroy private property.

Whence cometh this potential new power grab? From the lawyers, the academics, and the "experts," naturally.

The Center for Law and the Public's Health at Johns Hopkins and Georgetown Universities published a proposed "Model State Emergency Health Powers Act." The law would give the governor of a state the authority to declare an emergency in the face of "health threats," and would endow state officials with blanket powers to control citizens and their property in order to control the threat of disease.

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Private-Sector Safety Institute Empowers Patients

Physician, hospital, and consumer advocates unite to reduce medical errors, improve quality of care, and protect patient privacy

BY DIANE CAROL BAST

Leading physician, hospital, and consumer advocates announced at a December 11 news conference in Washington, DC the launch of a new initiative formed to improve patient safety and health care quality, the Patient Safety Institute (PSI).

A collaboration aimed at "putting the patient back into the picture," PSI is a nonprofit, voluntary initiative that will use existing technology to provide real-time, secure, patient-centric information.

PSI combines the power of technology with the strength of patient-provider relationships to improve health care and lower its costs.

"The PSI network will enable providers to immediately access vital blocks of information from disparate sources, at any time and from any point of care, and will dramatically enhance patient safety and improve treatment," said Jack Lewin MD, CEO of the California Medical Association and chair of PSI's Board of Directors.

PSI will deliver information in five key areas physicians agree are critical for delivering quality care: diagnoses, laboratory results, medications, allergies, and immunizations.

"Patient safety and privacy are the foundation of PSI; the National Consumers League is proud to be a partner in this important new endeavor," added Linda F. Golodner, president and CEO of the National Consumers League and a member of the PSI Board of Directors. "Only those who need to know—patients, their doctors, and their health care facili-

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MY TURN

AN EDITORIAL BY CONRAD MEIER

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The Heartland Institute
19 South LaSalle #903
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EDITORIAL OFFICES
The Heartland Institute
19 South LaSalle
Suite 903
Chicago, Illinois 60603
312/377-4000 voice • 312/377-5000 fax
email think@heartland.org

PRESIDENT
Joseph L. Bast

PUBLISHER
Nikki Saret

EDITOR
Diane Carol Bast

MANAGING EDITOR
Conrad F. Meier

ASSISTANT EDITORS
Greg Scandlen
Merrill Matthews

CONTRIBUTING EDITORS
Twila Brase, Bob Corkins
Dewey L. Crepeau, Dr. Miguel A. Faria
Tom Miller, Gerry Smedinghoff
Grace-Marie Turner

CARTOONISTS
Mike Shelton
Chuck Asay

DESIGN AND PRODUCTION
Kevin Fitzgerald
Jennifer Beranek

ADVERTISING MANAGER
Nikki Saret

CIRCULATION MANAGER
Latreece Vankinscott

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New Health Insurance Product Offered in Oregon

BY VICKI LANKARGE

In response to employers' cries for innovative products that shift more of the costs and responsibilities of health insurance to their employees, two companies are partnering to unveil a defined contribution health insurance plan to Oregon employers by July 1, 2002.

The new insurance product—which has yet to be named—is a joint venture of PacificSource Health Plans, an insurer located in Eugene, Oregon, and Patient Choice Healthcare, a Minneapolis-based company that creates and manages health care provider networks.

The product won't be an HMO, PPO, or POS health insurance plan. Its progenitors are calling it a "consumer-driven health care delivery model" that contains elements of a defined contribution health insurance plan.

While employers will pre-select the plan's basic benefit design, their employees will be able to shop around for the providers that best suit their individual health care needs. It will work like this:

- PacificSource Health will fund the insurance risk for fully insured employers or act as an administrator for self-insured employers.
- Patient Choice will create and manage a variety of health care provider networks, made up of different doctors and hospitals.
- Employers will define their employees' benefits structure.
- Employees will then shop the available provider networks for one that best fits their needs. Employees will have to choose a primary care physician (PCP) within their network and will pay premiums according to whether their PCP belongs to a low-, medium-, or high-priced network.

According to PacificSource, employers will typically pay the premiums for the lowest-priced provider networks, but members will be able to "buy up" to more expensive networks by paying the extra premium expenses.

Patient Choice encourages provider networks to compete with one another for patients based on cost, quality, and patient satisfaction, PacificSource says. Instead of negotiating fees, Patient Choice invites provider networks to bid on health care services. Health plan members are then able to review data collected by Patient Choice to compare cost, quality, and patient satisfaction, and then select the provider network that best matches their needs.

PacificSource says employers who choose the new plan will select a PacificSource health benefit plan, then each enrolling member will use the comparative data compiled by Patient Choice to select a personal provider network.

Vicki Lankarge writes for insure.com, the Consumer Insurance Guide.

Recession Strips Insurance from 725,000 Laid-off Workers

BY VICKI LANKARGE

While Congressional leaders and the White House debate an economic stimulus package that supports subsidizing people enrolled in COBRA, a new report says more than 725,000 laid-off workers have lost their health insurance since the recession began in March 2001.

The report, issued by Families USA, also reports that four in five people eligible for COBRA never actually receive it, because they can't afford to pay for it. According to Families USA, the national average cost of employer-provided family coverage under COBRA, plus a 2 percent administrative fee, is $7,194 per year, or $600 per month.

"Due to the recession, America's workers and their families are experiencing a fast-growing epidemic of health coverage losses," says Ron Pollack, executive director of Families USA. "This epidemic is undoubtedly causing havoc to the families most hurt by the recession. COBRA health coverage is a potential lifeline for laid-off workers, but, for most families, that lifeline is out of reach because it is unaffordable."

Under the federal COBRA (Consolidated Omnibus Budget Reconciliation Act) law, laid-off workers and their dependents can continue their health insurance for 18 months through their former employers if those employers have 20 or more employees. The laid-off worker is responsible for paying the full premium amount, plus an administrative fee of up to 2 percent.

Terrorist Attacks Accelerated Lay-offs

The Families USA report shows that the nation's economic deterioration accelerated in the wake of the September 11 terrorist attacks. From September 2001 to October 2001, the national unemployment rate jumped from 4.9 percent to 5.4 percent, the largest one-month increase since February 1986. The week ending September 29, 2001 saw 528,000 new unemployment claims across the country, the highest number of new weekly claims since July 1992.

Many of the workers who lost their jobs also lost their health insurance, because 91 percent of people under the age of 65 get their health insurance through their employers. While some regained benefits through their spouses' plans or other sources, a 1998 United States Census Bureau study found that 44 percent of workers who lose a job become uninsured, at least temporarily.

> **"Ninety-one percent of people under the age of 65 get their health insurance through their employers."**

Based on the Census Bureau's findings, Families USA estimates that approximately 345,000 workers who were laid off from their jobs in September and October joined the ranks of the uninsured. The report says this figure is probably much higher because it captures only the number of laid-off workers, not their dependents, who also lost their health insurance.

Costly COBRA

The report highlights the failure of COBRA to perform well as a safety net for many laid-off workers because of its high price.

According to Families USA, the national average monthly unemployment benefit is approximately $939. The cost of continuation of coverage under COBRA for a family (about $600 per month) would constitute almost two-thirds, or 64 percent, of the family's average monthly unemployment benefit.

The Senate Finance Committee has approved a provision in the economic stimulus proposal before Congress to subsidize 75 percent of COBRA premiums for newly laid-off workers.

"States already struggling with their budgets will need additional funding from the federal government to extend health care to those in need," says Pollack. "Congress must pass an economic stimulus package soon, and it must include health care protections for recently unemployed workers. A package without these protections will put millions of Americans at risk."

Vicki Lankarge writes for insure.com, the Consumer Insurance Guide.

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The Pulse

Free-market health care reform in the news

BY GREG SCANDLEN

You are invited to participate in an online discussion list dealing with many of the issues we report on here. To check it out, send an e-mail to HealthBenefitsReform-subscribe@yahoogroups.com. Later on, if you want to drop off, just send an e-mail to HealthBenefitsReform-unsubscribe@yahoogroups.com.

Commonwealth Expects 1 Million New Uninsured

Reuters Health reports on a new Commonwealth Fund study that anticipates 1 million newly uninsured as a result of the economic downturn and the 9/11 lay-offs. Reuters says, "the spike in uninsured Americans is likely to put a strain on low-income healthcare programs like Medicaid . . ."

Reuters adds that the Senate is debating a Democratic proposal to have the federal government pay up to 75 percent of the cost of COBRA for 12 months and spend $1 billion so states can add to the Medicaid rolls those who don't qualify for COBRA. (See the related story on health care rationing, page 6.)

Source: http://dailynews.yahoo.com/h/nm/20011115/hl/coverage_1.html

Commonwealth Wants Medicaid for Unemployed

The Commonwealth study says 37 percent of unemployed people are uninsured, and a "rise in unemployment could increase enrollment in Medicaid by as much as 3.3 million people." It also says the individual market is "unaffordable or inaccessible for most unemployed people."

Yet, while it is all in favor of subsidizing unaffordable COBRA coverage and expanded Medicaid, Commonwealth doesn't seem to think subsidizing individual coverage is a good idea. Can't help but wonder what the ultimate goal is here: individuals with good insurance coverage, or individuals with *government* insurance coverage.

Source: http://www.cmfw.org/media/releases/lambrew_release11132001.html

NCPA Says Many Uninsured By Choice

NCPA's Devon Herrick notes, in a *Brief Analysis* recently published, that many of the uninsured are "Uninsured by Choice."

Herrick points out, "From 1993 to 2000 the number of uninsured people in households with annual incomes above $75,000 increased by 63 percent, and the number in households with annual incomes from $50,000 to $75,000 increased by 48.2 percent. By contrast, the number of uninsured people in households with incomes under $25,000 fell by 25 percent."

He notes the disproportionate number of young people without insurance, who may simply feel insurance is not a good value for the money.

Source: http://www.ncpa.org/pub/ba/ba379/index.html

WTO Willing to Sacrifice Drug Patents

The World Trade Organization seems to have found its own answer to the question, "Why don't they like us?"

Because we enforce our intellectual property rights.

The Washington Post reports the WTO is trying to win some Third World friends by sacrificing the patent rights of pharmaceutical drug makers. A spokesman for a Ralph Nader organization is quoted as saying, "Is the WTO turning into the General Assembly of the United Nations?"

Apparently, some countries like Brazil and South Africa threatened to derail any trade agreements unless the WTO coughed up the drug patents. So the WTO sacrificed the interests of drug makers and drug research (and the people who benefit from such research) in a blatantly political deal.

If the WTO will sacrifice patent rights to avoid the criticism of demonstrators, what will it sacrifice the next time it meets a dozen people with picket signs?

Source: http://www.washingtonpost.com/wo-dyn/articles/A37845-2001Nov15.html

NCPA Says Drug Patents Critical for Innovation

Of course, our own Secretary of Health and Human Services, Tommy Thompson, and Senator Charles Schumer (D-New York) didn't help matters at the WTO when they threatened to override the Bayer patent on Cipro. The obvious argument at the WTO: If the U.S. can do it when they have an emergency, why can't we?

Frank Lichtenberg wrote a *Brief Analysis* for NCPA explaining why: Protection of intellectual property drives innovation. There are a number of specifics in the paper, including one that says, "65 percent of pharmaceutical inventions would not have been introduced if patent protection could not have been obtained."

Source: http://www.ncpa.org/pub/ba/ba380/index.html

AEI: Full Story on Cipro Issue

The American Enterprise Institute's Jack Calfee provides an even more detailed discussion of exactly what happened with the Cipro flap, including the cost and availability of other antibiotics, Canada's patent violation, and the details behind Secretary Thompson's peculiar position.

Source: http://www.aei.org/ps/pscalf011101.htm

Study: Mammograms Useless in Preventing Breast Cancer Deaths

A new report says there is no credible evidence that "mammograms reduce the risk of dying of breast cancer in women of any age," according to *The Washington Post*.

The very well-respected Danish Cochrane Collaboration authored the report. They reviewed each of seven large mammography trials, involving half a million women. They concluded five of the trials were either of poor quality or so flawed as to be discounted altogether. The two remaining studies were found to be "of medium quality" . . . and those two found no reduction in breast cancer deaths.

The *Post* article quotes Maryann Napoli of the Center for Medical Consumers in New York as saying, "mammography causes more harm than good . . . we have been sold a bill of goods."

And that conclusion is based solely on the clinical results, without consideration of costs. If the cost of mammography were added to the equation, the conclusion would have to be it is a gigantic rip-off. And yet, virtually every state mandates that insurance companies pay for periodic mammography screening. Someone is making a fortune off the procedure.

Source: Scandlen's Health Policy Comments, *National Center for Policy Analysis, 10/22/01*

Humana Makes Consumer-Driven Transformation

Jennifer Gordon has a major story on the transformation of Humana in *Business First* of Louisville.

She notes Humana is no stranger to reincarnation, starting as a nursing home company, and going to a hospital corporation, then to a managed care insurer.

Now, it is "taking the lead in reshaping its current industry (by) developing products suited to the preferences of the American public: consumer choice and business done via the Internet."

Gordon reports Humana's all-Internet product is called Emphesys and will do all business online, from enrollment to claims processing.

The other new product is less Web-dependent. Called Choices, it enables workers to pick any of six health plans—ranging from an MSA program with monthly premiums as low as $10, to a "rich PPO with premiums of about $80/month for an individual plan."

She quotes president and CEO Michael McAllister as saying, "Individual consumers are going to have a lot more financial involvement in the cost of things as they move through health care," and "employer-financed, consumer-centric health benefits products (are) . . . the next thing after managed care as we know it today."

Source: http://louisville.bcentral.com/louisville/stories/2001/11/19/story1.html

Entitlement Mentality in Dayton

David Miller, CFO of Dayton's Children's Medical Center, points out that people tend to make irrational decisions in health care, partly because they have come to expect insurance to pay for everything. He cites "the new field of behavioral finance" to explain such behavior. "[I]n (consumers') view," he writes, "a $50 medical service seems more costly than a $50 entertainment purchase."

He chides a colleague who decided to pay $2,000 more for a PPO because the HMO alternative didn't include his favorite doctor. "[B]y choosing the cheaper plan he could pay the doctor each time, tip him, and still have a lot of money left over."

Source: http://dayton.bcentral.com/dayton/stories/2001/11/19/focus2.html

NY Times Doesn't Like Consumer-Driven Health

The New York Times made quite a splash with its hatchet job on consumer-driven health care. The front-page article by health and business writer Milt Freudenheim was headlined, "A New Health Plan May Raise Expenses for Sickest Workers."

To make the point, Freudenheim uses a very remote scenario and implies it is typical. He supposes a family of three is required to pay a premium of $1,150 for a policy with a $5,000 deductible, with an employer-funded "allowance" of $3,000. Prescription drugs in this hypothetical case are not covered and are do not apply to meeting the deductible.

This poor family not only incurs medical expenses of $5,000, but it also suffers from asthma, high cholesterol, and mental ill-

THE PULSE continued on page 4

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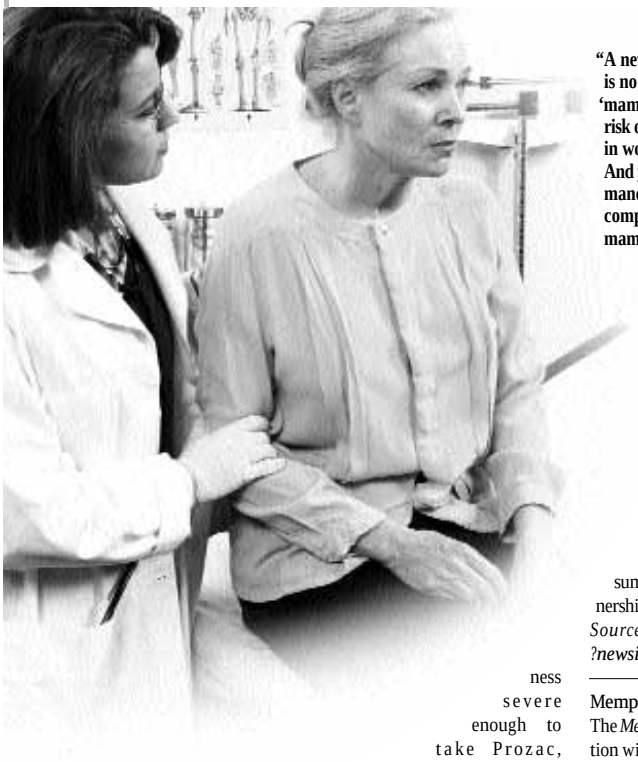

"A new report says there is no credible evidence that 'mammograms reduce the risk of dying of breast cancer in women of any age' . . . And yet, virtually every state mandates that insurance companies pay for periodic mammography screening."

The Pulse

CONTINUED FROM PAGE 3

ness severe enough to take Prozac, incurring another $2,484 in expenses, without the insurance plan paying a penny in benefits.

Freudenheim's comparison plan includes a family deductible of only $900, coinsurance of only 10 percent, and very generous prescription drug benefits, all of which costs the family a mere $300 more in annual premium.

Of course these are fantasy numbers, but the article uses them as if they are real-life scenarios. It implies this is just one example of the horrendous cost-shifting that employers are using to hoodwink their employees.

The article goes on to quote Uwe Reinhardt and Deborah Chollet as tsk-tsk-ing over employer and insurer greed. Reinhardt is quoted as saying, "The insurance industry has decided that if you are sick, you ought to eat the costs. It's a very dubious social policy."

Just amazing.

Source: http://www.nytimes.com/2001/12/05/business/05CARE.html

But *Dallas Morning News* Does

Fortunately, *The New York Times* is not the only publication reporting on the consumer-driven movement.

The *Dallas Morning News* ran an article by Patricia Rivera headlined, "New Option for Health Insurance: 'Consumer Driven' Policies Shift Cost Decisions to Employees."

Rivera reports on a meeting of the DFW Business Group on Health that attracted over 200 people to hear about defined contribution. She quotes a local PWC consultant as saying the movement is in its infancy, "but it's gathering steam very quickly." She also quotes a benefits manager from Texas Instruments as saying, "Our company wants to empower our employees to make their own health care decisions."

The article also notes the American Medical Association is supportive of the movement, while the American Hospital Association is critical. Lumenos' Doug Kronenberg is quoted as supporting the cost-containing effects: "When (employees) actually see that the amount in their account is disappearing, they're not afraid to ask why."

Source: DMN charges a fee for archived articles. The publication date was November 30, 2001.

So Does *National Underwriter*

National Underwriter is also reporting on the new movement. Barry Higgins writes, "MSAs Touted as an Answer to Rising Health Care Costs."

The article quotes an insurance broker and representatives of Aetna and Lumenos. Dr. Michael Parkinson, CMO of Lumenos, discusses both cost-containment and restoring the patient/physician relationship. He says by changing control of the dollars from a third party to the consumer, "it's much more likely that they'll ask the hard questions of the system."

He adds, "By aligning the financial incentives with consumer-friendly clinical information, the future for a true partnership between patients and their doctors will only be enhanced."

Source: http://www.insurancenewsnet.com/print.asp?newsid=Co:9xue9_odK1nZiXnJq

Memphis Commercial Appeal on D-C

The *Memphis Commercial Appeal* also weighs in on the new direction with an article by Associated Press writer Theresa Agovino. The article cites a Medtronics employee who is delighted with his new health plan because of less expense and more freedom. The article notes that established companies like Aetna, UnitedHealthcare, and Wellpoint are testing the concept, but it adds "smaller firms are the driving force behind the concept."

This time, the note of skepticism is sounded by Ed Kaplan of the Segal Company, who says "Employees are risk averse. They don't want to risk not going to the doctor, so I'm not sure how popular the plans will be."

Source: http://www.gomemphis.com/mca/business/article/0,1426,MCA_440_893598,00.html

San Diego Union Tribune Also on D-C

The *San Diego Union Tribune* also notes the trend in an article by Tony Fong headlined, "Know What Health Care Really Costs?" Fong reports that "after years of hand-wringing over consumer behavior, health plans and employers are taking aggressive steps to make patients aware of the cost of their health care."

Fong cites the Pacific Business Group on Health, which has recently agreed to make the Definity Health product available to all its members. He calls managed care "the standard all-you-can-eat-for-a-$10-co-payment" plan.

Of course, Fong quotes the academic skeptics, too, including UCLA's Richard Brown, who says, "I don't really see any good to this," and Princeton's Uwe Reinhardt, who seems to have changed his mind from the *NY Times* article. Reinhardt, according to the article, "compares American health-care consumers to teenagers with a parent's credit card: They want to charge whatever they want but want someone else to pay the bill."

Source: http://www.signonsandiego.com/news/uniontrib/sun/business.news_1b25health.html

For more information…

WWW For past issues of *Scandlen's Health Policy Comments* go to **http://www.ncpa.org/sub/shpc**

Market Catching up to MSAs

No publication is following the consumer-driven health care trend as well as *Employee Benefit News*. The December 1, 2001 issue contains four—count 'em, four!—relevant stories.

The first is by Karen Lee who writes, "Market Seen as Catching Up with MSA Concept." She quotes Proweh Health System's Michael O'Malley as saying, "MSAs are the building blocks of the future of health care." She notes the problems with the HIPAA-enabled MSAs, but says to "look for a run on MSAs" if the MSA expansion contemplated in patients' bill of rights legislation becomes law.

Meanwhile, Lee says large employers are doing their best to replicate the MSA concept through firms like Proweh, Lumenos, Definity, Vivius, and more recently Aetna and Humana.

Source: I couldn't find this one online, but the publication date was December 1, 2001.

Employers Getting Mixed Signals

Karen Lee has another *EBN* article that looks at employee response to the new conditions.

She cites the recent EBRI survey that says 80 percent of employees "are confident that their employers have picked the best available health plan," and "37 percent insist they would not be able to find the best insurance on their own." But she also notes, "34 percent of respondents claim to want to choose their own health insurance, with employers paying the same amount currently spent and employees making up the difference for a more expensive plan."

The article quotes me, Mark White of Watson Wyatt, and Paul Fronstin of EBRI for varying views.

Source: http://www.benefitnews.com/subscriber/Article.cfm?id=37880469

Quality Means Consumer Choice

Craig Gunsauley has another article in the same issue of *EBN*. "More sophisticated (employers) are trying to partner with employees and help them take responsibility for their coverage," he writes.

The article discusses disease prevention and management and employer efforts to affect quality of care, but it also quotes AHA's Jon Gabel as saying, "Most employers think quality is leaving the doctor alone and allowing employees to go to any doctor they want."

The article goes on to emphasize employer efforts to increase patient education and quotes even General Motors' Bruce Bradley as acknowledging that, "more and more consumer-driven decision making is a factor in health care coverage."

Source: http://www.benefitnews.com/subscriber/Article.cfm?id=37880472

Regulatory Issues in Defined Contribution

And Jill Elswick also covers the issue with an *EBN* article headlined, "Tax Risks Cloud DC Health Plans."

Elswick discusses the IRS's position (or lack thereof) on defined contribution, and Congressional interest in clarifying the issue. She also quotes PWC legal advisor Joe Walshe as saying, "I think (the IRS) is looking for some guidance as to which way they should go. I think they're a little skittish about what to do."

But Definity's Tony Miller says, "Each new deal inked leads to even more business as employer confidence in the new funding strategy increases."

Source: http://www.benefitnews.com/subscriber/Article.cfm?id=37880462

Greg Scandlen is senior fellow in health policy at the National Center for Policy Analysis in Dallas, Texas and assistant editor of Health Care News. *To sign up for his free weekly e-newsletter,* Scandlen's Health Policy Comments, *log on to www.ncpa.org/sub/. Email Scandlen at GMScandlen@aol.com.*

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POISON continued from page 1

The Center for Law and the Public's Health is funded by the federal government's Centers for Disease Control and Prevention. Lawrence O. Gostin, an attorney, is director of the Center. The Center's proposed law has been distributed to all 50 state governments.

Sweeping Powers

Under the proposal, a governor could declare a "state of public health emergency" without even consulting public health officials. Once the declaration was made, state officials would possess wide latitude to confiscate and destroy property as well as force immunization of the state's population.

The fundamental premise of the proposed law, according to the October 23 draft, is that "the government's foremost responsibility is to protect the health, safety, and well-being of its citizens."

> **"Public safety is a precondition for the exercise of rights, not an end in itself."**

We most emphatically demur. This type of legislation is abhorrent: medically, morally, and constitutionally. According to our Declaration of Independence, "Governments are instituted among Men" to secure "certain unalienable Rights" and that "among these are Life, Liberty, and the pursuit of Happiness." Securing a person's rights—not protecting citizens—is the foremost government responsibility. Public safety is a precondition for the exercise of rights, not an end in itself.

Dumb Like a Fox

The proposed law also demonstrates an appalling ignorance (or maybe a shrewd awareness) of how governments actually operate. In Washington state, for example, the threshold for government declaration of "emergency" is very low.

Several years ago, in order to avoid the possibility of political accountability in a public vote, the governor declared financing of a sports stadium to be such an "emergency." A good-government group, Citizens for Leaders with Ethics and Accountability Now! (CLEAN), sued. In *CLEAN vs. State of Washington*, the state supreme court "upheld the Legislature's use of an emergency clause in the law passed to provide public financing for the new Mariners' stadium in Seattle."

The court concluded the governor's job is to implement the laws written and defined by the legislature; the governor and legislature said there was an emergency, so there must be one, so the use of the emergency powers act was appropriate.

The emergency powers act proposed by the Center for Law and the Public's Health is open to even broader interpretation. "Threat" is an even squishier word than "emergency."

Admittedly, some of the provisions in the model law have 30- and 60-day limitations. But governments have been known to play endless "clocking" games with such limitations. There's also nothing to keep the governor from declaring rolling threats, one after another, if he or she desires.

> **"We're not against a little creative interpretation, should a compelling need arise. What we are against is this 'stockpiling' of excessive law and regulation."**

Health Care Takeover

One provision of the proposed law (Section 402) gives state officials the power to do what the federal government has been trying to do for half a century: take over medicine.

Compulsory vaccination is, of course, no new thing. Seizure of medical (and other) facilities in the face of "potential" emergencies is.

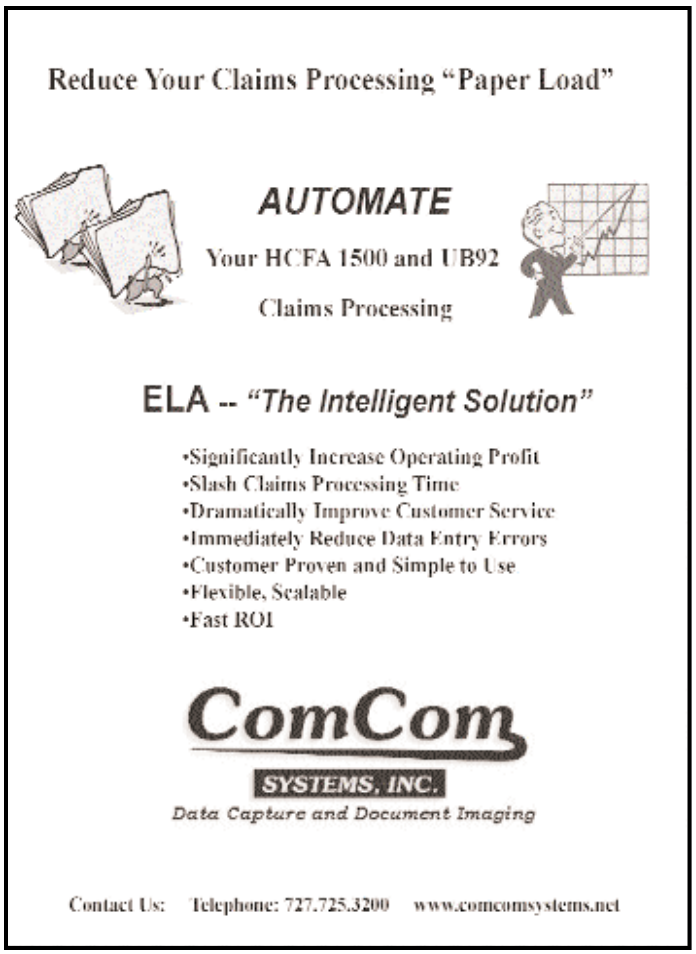
We doubt most public health or other government officials would run a hospital procured "by condemnation" under this law any better than the previous owners. In fact, we suspect the opposite. Seizure would cause enormous disruption in the routine activities that are also necessary to protect public health. New administrators and outside "experts," probably ignorant of local conditions and needs, would trash the system.

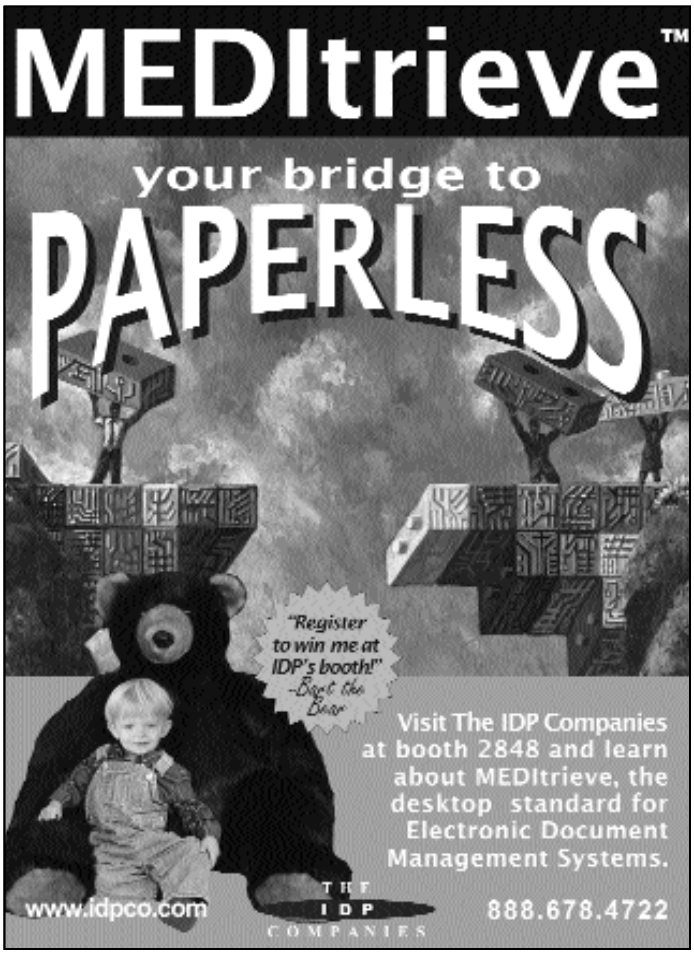
We believe it unlikely that state government officials need the sorts of emergency powers contemplated by this proposal. Although we do recommend all states review their present laws to make sure, we trust that, in all but exceedingly rare circumstances, existing state powers are more than adequate to the task. If faced with unprecedented circumstances, we're confident state governments will act with unprecedented swiftness.

In addition, government officials throughout the ages have bent the law in response to unprecedented circumstances. We're not against a little creative interpretation, should a compelling need arise. What we are against is this "stockpiling" of excessive law and regulation.

In government, nothing's quite so permanent as "temporary emergency measures." Few governments will wait for an "emergency" to start before using their new powers, once on the books.

Michael Arnold Glueck MD writes extensively on medical, legal, disability, and mental health reform. Robert J. Cihak MD is the immediate past president of the Association of American Physicians and Surgeons (AAPS). Glueck and Cihak write a weekly column for WorldNetDaily and regular contributions for Health Care News.

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Feds Threaten to Close Medicaid Loophole

State officials protest, saying they've come to depend on inflated reimbursements

BY CONRAD F. MEIER

A bipartisan group of federal policymakers has vowed to block any plans the Bush administration might have to close the so-called "upper payment limit" loophole in the Medicaid state reimbursement formula.

Healthy Roads

According to CongressDaily/AM Reports, Members of Congress from both chambers and both parties are "vowing to block or at least delay" a proposed rule phasing out a Medicaid loophole. A similar battle took place during the Clinton administration's tenure, when Congress successfully "watered down" a proposal to curtail the states' use of the upper payment limit.

Medicaid currently permits state budget officials to reimburse health care providers several times more than the standard Medicare rate for services provided to Medicaid patients. The Medicaid reimbursement formula might permit state officials, for example, to request federal matching funds of 200 percent of the Medicare rate for an x-ray or other lab work.

Once they've received the federal matching funds, state budget officials can "share" the inflated reimbursement with the care providers, sending them perhaps 135 percent of the standard Medicare rate for the x-ray. What they don't turn over to the care providers can be used for any budgetary purpose, from fixing potholes to increasing salaries for state employees. There is no law or regulation requiring the funds be used only for health care-related services.

The Clinton administration sought to reduce the upper payment limit to 150 percent of the rate a service would be reimbursed under Medicare.

But Tom Scully, administrator of the Center for Medicare and Medicaid Services (CMS), said CMS will seek to reduce the upper payment limit to 100 percent, effectively closing the loophole. He said the 150 percent level was "well-meaning, but it's turned out to be a hole you can drive a truck through."

Protecting Their Turf

Many lawmakers say closing the loophole would hurt state and community services like free medical clinics and public hospital systems. States that have used the over-payment of funds to pay for health services would see their federal funding greatly reduced.

"I've got hospitals out there that if they are taken back to 100 percent, they fold," said Senator Blanche Lincoln (D-Arkansas), who has introduced language in the Senate's version of the economic stimulus bill to delay for six months implementation of the proposed rule.

CongressDaily/AM also reports the rule has particularly upset lawmakers from California, which uses loophole funds to subsidize the state's emergency and trauma care system. "This longstanding program is a cornerstone of financial support for the state's health care safety net, and all federal Medicaid dollars are used exclusively for health care purposes," 47 members of the California delegation wrote in a letter to House leaders. "Therefore, any steps taken to rightfully eliminate abuses of the Medicaid program under [the loophole] should not undermine California's program."

Scully says the plan to close the loophole will go forward. "If Congress wants to change it, they're going to have to finance it."

Here Comes Government Rationing

Rising costs, falling state revenues make restrictions on health care use inevitable

BY CONRAD F. MEIER

Opponents of government control of health care—among them economists, policy analysts, and health care practitioners—have often warned that government control inevitably means government rationing of care. They've pointed to Canada, Great Britain, and other countries where such rationing routinely takes place. In the U.S., single-payer state plans, Medicare, and Medicaid would appear to be particularly vulnerable to rationing, on the basis of political whim as well as turns in the economy.

During the economic ups of the 1990s, states added benefits to their Medicaid programs to care for low-income families. Now, because of a strained economy, tax receipts are down . . . and states are finding it necessary to break their promises and ration medical care as a way to balance their budgets.

Rationing Cuts a Wide Path

In a November 14, 2001 *Wall Street Journal* article titled "States Look to Ration Health Care," Robert Gavin finds state health care costs are growing at their fastest rate in a decade: 9 percent a year. At the same time, states are struggling with budget shortfalls totaling an estimated $15 billion.

For more information…

WWW The full text of Robert Gavin's *Wall Street Journal* article, "States Look to Ration Health Care," is available to WSJ Online subscribers at **http://interactive.wsj.com/articles/SB1005686520537207320.htm.**

Gavin reports that if the nation's unemployment rate rises to 6.5 percent—roughly a single point above what it is now—states may have to absorb nearly two million more people into Medicaid.

Some states are already beginning to reduce health care benefits. Oregon, for example, recently proposed reducing benefits for 90,000 low-income residents by adding cost-sharing co-payments in order to extend coverage to 40,000 others. Utah wants to cut benefits by about 3 percent.

Under current Medicaid rules, states are permitted to cut optional benefits, like prescription drugs. They may also exclude certain beneficiaries, like low-income adults without children. The law requires only that equal benefits be provided to all participants in the program. States cannot, for example, cut prescription drug benefits for one group of beneficiaries without cutting benefits for all enrollees in the program.

> **"[I]f the nation's unemployment rate rises . . . roughly a single point above what it is now, states may have to absorb nearly two million more people into Medicaid."**

Bring Back the Free Market

Commenting on the state of health care in the current economic environment, Representative Charlie Norwood (R-Georgia) had harsh words for a health care system run not by patients and providers, but by governments and other third-party payers. Addressing the October 20 annual meeting of the Georgia Society of Clinical Oncology, Norwood noted that "every provider, every patient, every hospital in the country is reeling from the same disease: health care rationing, stemming from both managed care and Medicare/Medicaid."

Norwood encouraged the audience of cancer-care practitioners to support a return to private-sector health care.

"If you were strictly private sector," Norwood noted, "your rates would reflect what you needed to run your practice, provide care, pay for your schooling, and make a profit.

"I'm sure each of you would be happy to sell chemotherapy drugs at cost, or not at all," Norwood commented, addressing a practice currently under investigation by federal Medicare officials and Congress, "*if* you were taking in a reasonable charge for your direct services. But Medicare government bureaucrats have cut your treatment reimbursement to a level that you can't stay in business. Your only option is to make your profit on the sale of chemotherapy drugs."

Medical Savings Accounts, Norwood said, are among the solutions to health care providers' predicament. MSAs provide "instantaneous reimbursement for services," he explained, create the perfect wellness incentive, and help restore a market in health care.

"For the first time in decades, patients are going to be paying attention to your rates. Their health care expenses will once again be in their own hands. Charge a fair amount for your services," Norwood urged.

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PSI continued from page 1

ties—will have access to patient data."

Medical errors are believed by some to be a leading cause of death and disability in the United States, causing more fatalities each year than AIDS, breast cancer, and motor vehicle accidents combined. "The time is right for a solution formed by and for those at the intersection of quality care: patients, physicians, and hospitals," said Lewin. "PSI's governance, privacy principles, and technology standards will elicit the patient trust and confidence necessary for the PSI solution to be accepted across the country."

PSI's Board of Directors includes prominent advocates drawn from the patient, physician, and hospital communities. In addition to Lewin and Golodner, directors are Don C. Black, president, Child Health Corporation of America; Twila Brase RN, PHN, president, Citizens' Council on Health Care; Jane L. Delgado Ph.D., president & CEO, National Alliance for Hispanic Health; William F. Jessee MD, CMPE, president & CEO, Medical Group Management Association; and Daniel H. Winship MD, vice chancellor of health affairs and CEO, University of Missouri-Columbia Health System, and member, Executive Committee of the University Healthsystem Consortium.

For more information…

WWW Contact: Liz Kapusnick at 202/715-0513, email ekapusnick@brodeur.com or Brian Hoyt at 202/715-0503, email bhoyt@brodeur.com. Or visit the Patient Safety Institute's Web site at **http://www.ptsafety.org**.

> **"PSI combines the power of technology with the strength of patient-provider relationships to improve health care and lower its costs."**

In addition to being guided by a consumer and provider-based board, PSI is advised by Dee Hock, founder and CEO Emeritus of VISA and member of the Business Hall of Fame. Thirty-five years ago, Hock pioneered the concept of using an open communications network to allow competing institutions to securely transmit a limited set of consumer data, paving the way for today's robust credit card and ATM industry. In applying this model to the health care industry and the issue of patient safety and quality of care, PSI will go one step further by giving the consumer an equal voice in the system's governance.

Nationwide Expansion

To facilitate expansion of PSI nationwide, PSI will offer access to the system through publicly available, open standard technology.

Offering both convenience and confidentiality, PSI will allow providers to securely access clinical information using the technology of their choice, such as a handheld device at the patient's bedside or a networked computer in their office.

Beta sites that demonstrate the PSI system will be up and running by mid-2002. Based on the results of those test sites, PSI anticipates a national rollout of the PSI system sometime in 2003.

Focus on Patient Security, Privacy

Protecting the privacy and security of sensitive patient information is key to the mission of PSI and to its Board of Directors.

"PSI sets a new standard of respect for patients and the patient's right to privacy and personal autonomy," said Board member Brase, who also serves as a contributing editor to *Health Care News*. "It is my hope that new consumer expectations will quickly lead to the adoption of PSI standards and privacy principles across the entire health care industry."

PSI will employ an enhanced security technology to maintain patient confidentiality at a higher standard than is currently in use or mandated. This enhanced security feature requires that the digital identity of the patient, physician, and clinic or hospital be authenticated before the patient's clinical information is released to the patient-approved physician. Identifiable patient data will continue to be stored under the jurisdiction of the patient's physician and hospital and at their current locations.

PSI is a voluntary initiative; the patient, his or her physician, and their hospital all must deliberately choose to participate and can opt out of the system at any time.

> **"PSI's Board of Directors includes prominent advocates drawn from the patient, physician, and hospital communities."**

Core Founding Partners

PSI supports open standards and an open access policy for all health care vendor organizations. For the PSI demonstration phase, initial support was provided by Core Founding Partners (CFPs) selected by the PSI Board of Directors to demonstrate the efficacy, viability, and inter-operability of the PSI communications network in an actual health care community environment.

The CFPs include Avaya, Cingular, First Consulting Group, Hewlett-Packard Company, Netegrity, SeeBeyond, TeleTech, and Williams Communications.

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Oregon Health & Science University offers a variety of educational programs in Medical Informatics designed to train individuals for careers in the development and management of health care information systems. Programs are available on-campus and via distance learning:

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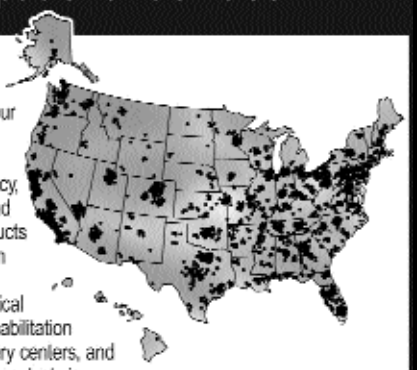

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State Legislative Update

COMPILED AND EDITED BY CONRAD F. MEIER

ALASKA

The Alaska Senate's Health, Education and Social Services Committee formed a subcommittee to study health care and welfare reform. The new subcommittee will review cost containment measures for Medicaid programs, as well as the state's CHIP program. The subcommittee will also hold hearings on such issues as expanding health insurance coverage and rural health care needs.

Health care is the state's most expensive service behind education, with Medicaid costs increasing 10 percent annually. Health costs are expected to surpass education within five years, and the state's Medicaid costs are expected to double within seven years.

State Sen. Lyda Green (R), chair of the Health, Education and Social Services Committee, said, "It has been years since the Legislature has taken a comprehensive look at our state's growing health care costs."

CALIFORNIA

Faced with an anticipated $12.4 billion deficit by June 30, 2003, California Governor Gray Davis (D) announced he will seek $2.2 billion in spending cuts, including a delay in the planned expansion of the state's CHIP program to cover parents under the KidCare program.

The $12.4 billion deficit represents 15 percent of the state's general fund. It exceeds this year's $10.3 million budget for Medi-Cal, the state's Medicaid program.

Davis proposed to delay until July 2003 a planned expansion of Healthy Families, the state's CHIP program, to include coverage for some low-income parents. The state is awaiting federal approval of a waiver for the expansion. The delay would save the state an estimated $160.5 million in 2002-03.

FLORIDA

Some of Florida's social service programs, including ones that care for children and the elderly, are bracing for budget cuts as state lawmakers attempt to balance the state budget. Most states operate intervention programs, but in Florida, not-for-profit and private companies contract with the state to handle such services as child care, drug rehabilitation, and elder care.

IDAHO

The number of children enrolled in the state's Medicaid and CHIP programs has increased despite a decision by state lawmakers to stop advertising the program.

State lawmakers, concerned about costs for the state's Medicaid program, which includes the Medicaid-expansion CHIP program, passed a bill last spring to end a $500,000 television and radio ad campaign. Since last October, Idaho has not advertised for either Medicaid or CHIP.

Karl Kurtz, director of the state Health and Welfare Department, said, "The department has greatly curtailed its CHIP outreach effort. We are doing the bare minimum for outreach allowed by federal law."

State Senator Stan Hawkins (R), who sponsored the legislation that halted the advertising, said the number of children covered in Medicaid and CHIP "is growing too quickly." The number of children enrolled in the program has reached 100,000, almost double the figure in 1999, while the state's CHIP program covers about 13,000 children.

The Spokane *Spokesman-Review* reported the number of children enrolled in the Medicaid program could reach 115,000 by 2003.

INDIANA

Indiana pharmacists and drugstores dropped a court challenge against state Medicaid officials after the latter agreed to reverse cuts in pharmacy fees and consider cost-saving ideas from the private sector.

Governor Frank O'Bannon (D) had planned to cut nearly $100 million from the state Medicaid program's $1.15 billion drug budget by cutting from $4 to $3 the fee pharmacists receive for filling Medicaid prescriptions and by controlling drug markups by as much as half. The governor's plan faced repeated court challenges.

A hearing had been set for November 15, 2001 after pharmacies and drugstores complained the cuts violated an earlier court order. Given the new developments, the hearing has been postponed indefinitely.

IOWA

State officials have begun enrolling seniors in a new program offering discounts on prescription drugs. The program, called Iowa Priority, is described by its creators, Gov. Tom Vilsack (D) and Sen. Tom Harkin (D), as the "first of its kind in the nation."

Under the program, a not-for-profit co-op negotiates prices with drug companies. Although Harkin said seniors would see "significant price drops" by participating in the program, pharmacists don't agree, saying the actual discounts would range between 10 and 20 percent. The amount of savings is linked to how many seniors enroll. According to Department of Health data, about 300,000 residents are eligible.

MASSACHUSETTS

Lawmakers approved a $22.6 billion budget that cuts funding for human services and a variety of public health programs, the *Boston Globe* reports. Facing a $1.4 billion budget deficit, lawmakers cut about $650 million from earlier spending plans.

While the new budget plan includes reductions in public health funding, it spares the state's pharmacy program for seniors and restores the state's hepatitis C prevention campaign.

In addition to numerous Democrats who voted against the budget proposal, 22 Republican House members also voted nay, complaining the budget process excluded them from "major decisions." Nearly all of the final decisions on cuts were made by House Speaker Thomas Finneran (D) and Senate President Thomas Birmingham (D), according to the *Boston Globe*.

Also reported by the *Globe*, Republicans complained the budget was released less than a day before the vote, leaving no time to offer amendments. Acting Governor Jane Swift (R) said the plan was a "mess." She promised "numerous" line item vetoes would be forthcoming.

MICHIGAN

In an effort to cut $42 million from its burgeoning Medicaid budget, lawmakers put several hundred popular drugs on a state-controlled formulary, where they will remain unless manufacturers agree to price controls.

This year, drugs for Medicaid will cost an estimated $1.1 billion. To bring that spending under control, the legislature passed a law last year directing the state Department of Community Health to create a rationing program to lower Medicaid costs.

Under the department's proposal, a medical panel will select as "best in class" two drugs from each of 40 therapeutic categories. For drugs not on the list, doctors need several authorizations from the state before prescribing them, in an effort to discourage use.

Drug companies say Michigan's proposed program would "deny" drugs to low-income patients. The Pharmaceutical Research and Manufacturers of America (PhRMA) suggested a state-run prevention-oriented program to cut costs. State officials rejected the idea, saying such programs will not save "as much money as deeper discounts."

"Indiana pharmacists and drugstores dropped a court challenge against state Medicaid officials after the latter agreed to reverse cuts in pharmacy fees and consider cost-saving ideas from the private sector."

The Michigan formulary is similar to one passed by Florida last year. So far, Michigan has rejected the kind of negotiating Florida accomplished with Pfizer and Bristol-Myers Squibb to keep their drugs off the restricted list in exchange for managing preventive care programs to cut medical expenses.

PhRMA is considering a legal challenge to the Michigan plan. A suit against the Florida program is pending in federal court.

PENNSYLVANIA

The state lottery is projected to run a deficit of nearly $200 million by the end of the fiscal year 2003-2004 budget cycle if the state cannot hold down costs for its senior prescription drug plan.

The lottery subsidizes prescription drug purchases for low-income seniors through the Pharmaceutical Assistance Contract for the Elderly (PACE). Lottery proceeds are also directed to such services as in-home assistance for the senior population.

Bigger prize payouts, increasing drug costs, and higher prescription drug utilization have put the lottery in financial jeopardy. The lottery fund could be running at a $188 million deficit by the end of the 2003-2004 fiscal cycle.

Pennsylvania is the only state that uses lottery proceeds to subsidize senior drug purchases.

Democrats have proposed a plan to "take on the drug industry" by requiring the state to join a multistate coalition that would negotiate discounts with drug makers.

WISCONSIN

Responding to complaints from senior citizens about the PrimeCare Gold health plan, State Rep. Timothy Carpenter (R) has called for hearings on the issue before the Wisconsin Assembly's Aging and Long Term Care Committee.

PrimeCare Gold, a Medicare+Choice plan operated by Minnesota-based UnitedHealthcare, serves 16,000 residents of the Badger State. Carpenter received criticism from senior advocacy groups for the "dramatic co-payment increases" scheduled for 2002.

In response to the increases, the Wisconsin Bureau of Aging and Long Term Care has begun warning senior citizens against enrolling in PrimeCare Gold, saying the increases could "cost seniors more than they would pay under traditional Medicare."

Sources: The Council for Affordable Health Care (CAHI) http://www.cahi.org and its member companies provided information for this State Legislative Update. Additional material was provided by the National Association of Health Underwriters (NAHU), http://nahu.org/government, by http://bizjournals.com, http://stateline.org, and Lexis/Nexis research.

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States Don't Wait on Patients' Rights

Forty-six states regulate the relationship between managed care plans and consumers

BY MARY GUIDEN

When North Carolina Governor Mike Easley (D) signed "patients' bill of rights" legislation, the state joined 45 others that have given more legal power to health care consumers.

There's no gold standard for a patients' bill of rights, but state measures generally require HMOs to tell patients what services are paid for. Patients also get the right to air complaints and challenge refusals to pay for care.

California was the first state to enact a patient's bill of rights, in 1994. To date:

- 48 states prohibit health plans from telling doctors what they can and cannot say to patients;
- 47 states require plans to pay for emergency care;
- 41 states give women direct access (without requiring a referral) to an OB/GYN; and
- 40 states have an appeals process for patients to use if they're not happy with a doctor's decision.

Toughest in the Country

State officials say North Carolina's bill of rights is the toughest in the country. Officials there looked at other state laws and pending federal bills before deciding what their bill of rights would look like.

"We extracted the strongest provisions of all the measures and we even added a few new ones," says Alan Hirsch, policy director for Easley, who unveiled the legislation last year.

Policymakers decided to give doctors more say in prescribing drugs. Many health plans restrict the drugs they'll pay for by putting them on a list known as a formulary.

Under North Carolina's new law, "if a doctor believes a particular drug is needed by a patient, he has the ability to prescribe it" even if it's not on the formulary, says Hirsch.

Hirsch says in crafting the measure, there wasn't a lot of discussion about potential congressional action. "We're not too terribly concerned that Congress would enact a bill that would lower patient protections. We're reasonably confident our law will stand," he says.

Federal Proposals Weak

Other states, however, *are* concerned about what will happen to laws already on the books if a federal patients' bill of rights measure passes. Some congressional proposals would weaken state mandates.

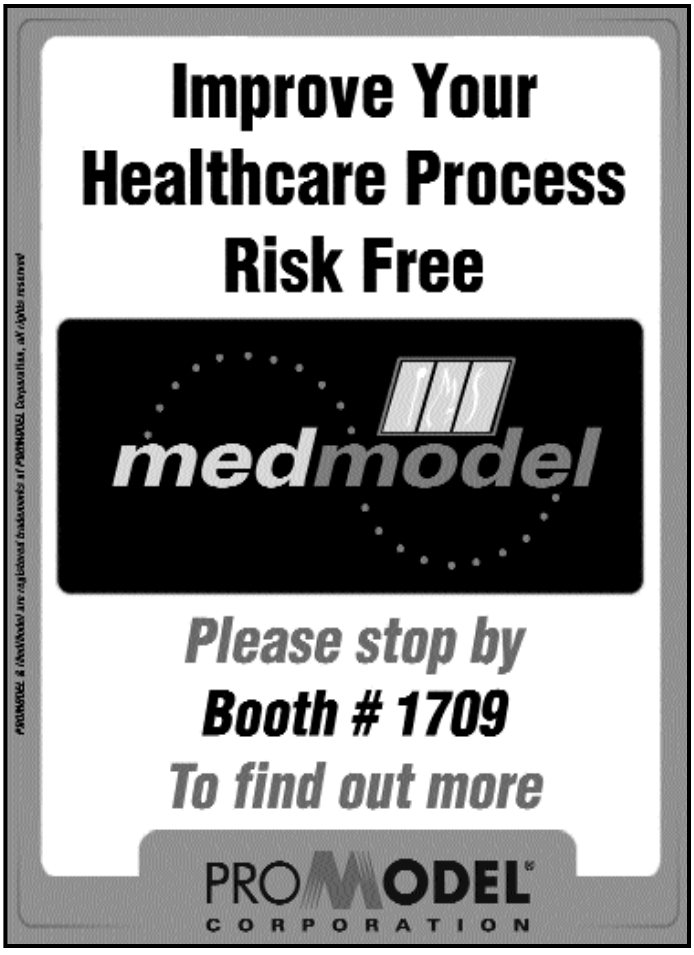
"The federal patients' bill of rights is weaker than most of what the states have, and federal lawmakers don't want to invalidate some of the really good stuff states have done," says Rachel Morgan of the National Conference of State Legislatures.

"The biggest impact on states is whether they'll be required to have existing laws certified or whether the feds will grandfather them in," she says. Full-fledged certification would require the federal government to create a new agency to review what states have done. "It's a guessing game until Congress gets something in black and white," Morgan says.

Up to one-third of Americans are largely unaffected by state patients' rights laws. That's because most employer-sponsored health plans are regulated by the federal Employee Retirement Security Act (ERISA), and thus are exempt from the state mandates.

Mary Guiden is staff writer for stateline.org.

STATE	YEAR ENACTED	PROVISIONS
Alaska	1998	Ban on gag clauses, direct access, bans financial incentives
Arizona	2000	Grievance procedures, direct access, experimental treatment
Arkansas	1997	Inpatient care after childbirth, mastectomies, provider credentialing
California	1994	Information disclosure, emergency care services, appeals
Colorado	1997	Consumer grievance process, ER, prescription mandates
Connecticut	1997	Ban on gag clauses, grievance process, medical records, ER
Delaware	1998	Bans financial incentives, grievance process, network adequacy
Florida	1997	Ban on gag clauses, grievance process, data collection, direct access
Georgia	1996, 1999	Disclosure, grievances, confidentiality, independent appeals
Hawaii	1998	Ban on gag clauses, ER care, independent review
Idaho	1997	Direct access, emergency care, out-of-network providers
Illinois	1999	Ban on gag clauses, consumer assistance, emergency care, appeals
Indiana	1998	Ban on gag clauses, grievances, medical records, drug formularies
Iowa	1999	Disclosure, emergency care, independent appeals, report cards
Kansas	1997	Ban on gag clauses, grievance process, ER, direct access
Kentucky	1998, 2000	Grievance process, ER, medical records, direct access
Louisiana	1997	Consumer grievances, financial disincentives, quality assurance
Maine	1996, 2000	Disclosure, reporting, gag clauses, ER, experimental treatment
Maryland	1995	Oversight of plans, certification standards
Massachusetts	2000	External review, ER, grievance process, mandated kids mental health services
Minnesota	1997	Ban on gag clauses, disclosure, ER, medical records
Mississippi	1995	Certification standards only
Missouri	1997	Ban gag clauses, data collection, direct access, ER, medical records
Montana	1997	ER, access, provider selection, ban gag clauses, premium rate restrictions
Nebraska	1998	Ban gag clauses, grievance process, ER, network adequacy
Nevada	1997	Ban gag clauses, disclosure, ER, financial disincentives
New Hampshire	1997	Consumer grievance, ban gag clauses, medical records, network adequacy
New Jersey	1997	Ban gag clauses, grievance process, financial incentives
New Mexico	1997, 1998	Ban gag clauses, grievance process, network adequacy
New York	1996	Disclosure, grievance process, direct access, quality of care
North Carolina	2001	Grievance process, Rx formulary
North Dakota	1999	Ban financial incentives, ER, whistleblower protections
Ohio	1997	Consumer grievance process, ER, network adequacy, genetic testing
Oklahoma	1997, 1999	Referrals, ER, ban gag clauses, quality of care, consumer grievances
Oregon	1995, 1997	Consumer grievances, ER, disclosure, network adequacy
Pennsylvania	1998	Ban gag clauses and financial incentives, consumer grievance
Rhode Island	1996	Certification, disclosure, confidentiality, ban gag clauses
South Carolina	1998	Ban gag clauses, disclosure
South Dakota	1999	Network adequacy, quality of care, ban gag clauses, register managed care plans
Tennessee	1998	OB/GYN access, eye care, network adequacy, formularies
Texas	1997	Ban gag clauses, consumer grievance, ER, quality of service
Vermont	1996	Annual review, disclosure, ban gag clauses, quality assurance
Virginia	1995, 1996, 1998, 1999	Appeals, emergency care, ban gag clauses, medical records
Washington	1996, 2000	Disclosure, ban gag clauses, consumer grievance, direct access
West Virginia	2001	Disclosure, financial incentives ban, second medical opinion, grievances
Wisconsin	1998	Emergency care, gag clauses, director certification, experimental treatment



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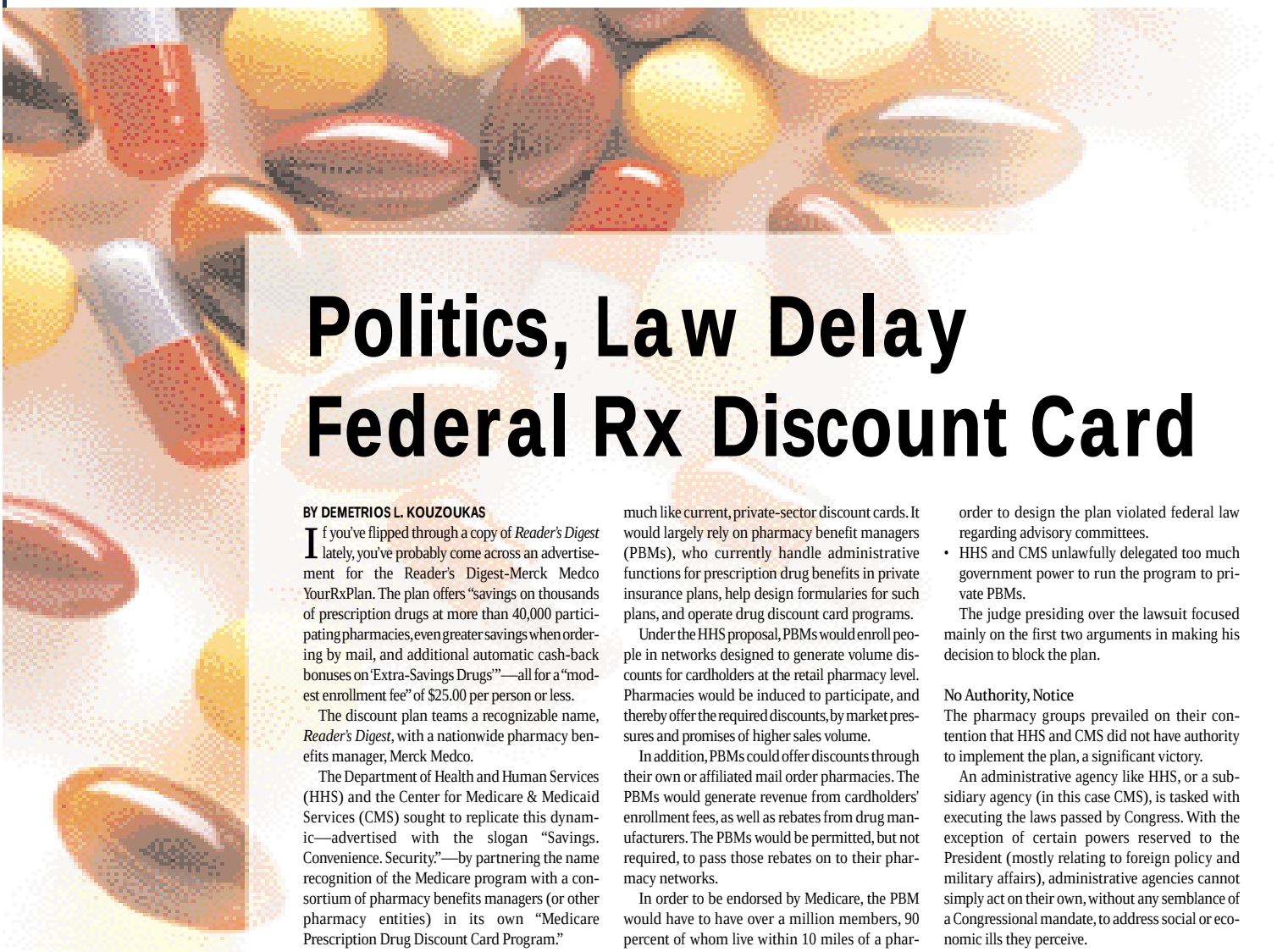

Politics, Law Delay Federal Rx Discount Card

BY DEMETRIOS L. KOUZOUKAS

If you've flipped through a copy of *Reader's Digest* lately, you've probably come across an advertisement for the Reader's Digest-Merck Medco YourRxPlan. The plan offers "savings on thousands of prescription drugs at more than 40,000 participating pharmacies, even greater savings when ordering by mail, and additional automatic cash-back bonuses on 'Extra-Savings Drugs'"—all for a "modest enrollment fee" of $25.00 per person or less.

The discount plan teams a recognizable name, *Reader's Digest*, with a nationwide pharmacy benefits manager, Merck Medco.

The Department of Health and Human Services (HHS) and the Center for Medicare & Medicaid Services (CMS) sought to replicate this dynamic—advertised with the slogan "Savings. Convenience. Security."—by partnering the name recognition of the Medicare program with a consortium of pharmacy benefits managers (or other pharmacy entities) in its own "Medicare Prescription Drug Discount Card Program."

Politics Derails Rx Relief

The HHS initiative sparked a lawsuit by chain and independent pharmacies to stop its implementation. The initiative is now being reformulated. The lawsuit's success was largely a result of the speed with which HHS and CMS introduced the initiative.

"[A]dministrative agencies cannot simply act on their own, without any semblance of a Congressional mandate, to address social or economic ills they perceive."

The initiative was introduced quickly because HHS and CMS felt pressured to produce some tangible action on prescription drugs before year-end 2001. Other efforts earlier in the year had been stymied. Congres-sional leaders declared "dead on arrival" the Bush administration's "Immediate Helping Hand Program," designed to give block grants to states to expand prescription drug coverage for low-income seniors. And it looked like a prescription drug plan for Medicare wouldn't be passed until at least 2002.

Plan Summary

The Medicare discount card would have worked much like current, private-sector discount cards. It would largely rely on pharmacy benefit managers (PBMs), who currently handle administrative functions for prescription drug benefits in private insurance plans, help design formularies for such plans, and operate drug discount card programs.

Under the HHS proposal, PBMs would enroll people in networks designed to generate volume discounts for cardholders at the retail pharmacy level. Pharmacies would be induced to participate, and thereby offer the required discounts, by market pressures and promises of higher sales volume.

In addition, PBMs could offer discounts through their own or affiliated mail order pharmacies. The PBMs would generate revenue from cardholders' enrollment fees, as well as rebates from drug manufacturers. The PBMs would be permitted, but not required, to pass those rebates on to their pharmacy networks.

In order to be endorsed by Medicare, the PBM would have to have over a million members, 90 percent of whom live within 10 miles of a pharmacy in the network; have experience relevant to operating a drug discount card program; limit its enrollment fee to no more than $25; disclose pricing information for commonly prescribed medications; and participate in an exclusivity scheme designed to ensure that no cardholder is enrolled in more than one program.

Entities other than PBMs could apply for Medicare endorsement so long as they met all those requirements. HHS and CMS hoped cardholders would shop for the plan offering the best savings for their prescriptions, resulting in discounts of 25 percent or more.

Legal Snags

The program's implementation was blocked by a federal judge after the pharmacy industry, joined by Congressman Pete Stark (D-California), filed suit claiming several legal and procedural flaws.

The lawsuit made five specific complaints about the Medicare Prescription Drug Discount Card Program:

- HHS and CMS did not have the authority to create the program.
- HHS and CMS did not follow proper procedures in implementing the program.
- The program's eligibility requirements were arbitrary and an abuse of HHS' discretion to execute the laws.
- Meetings HHS and CMS held with PBMs in order to design the plan violated federal law regarding advisory committees.
- HHS and CMS unlawfully delegated too much government power to run the program to private PBMs.

The judge presiding over the lawsuit focused mainly on the first two arguments in making his decision to block the plan.

No Authority, Notice

The pharmacy groups prevailed on their contention that HHS and CMS did not have authority to implement the plan, a significant victory.

An administrative agency like HHS, or a subsidiary agency (in this case CMS), is tasked with executing the laws passed by Congress. With the exception of certain powers reserved to the President (mostly relating to foreign policy and military affairs), administrative agencies cannot simply act on their own, without any semblance of a Congressional mandate, to address social or economic ills they perceive.

The pharmacy groups charged, and the judge agreed, this is precisely what HHS and CMS did in establishing the Medicare Prescription Drug Discount Card Program.

In defending themselves against the charge, the agencies cited their legal authority to "establish a health insurance advisory service program to assist Medicare-eligible individuals with the receipt of services under the Medicare and Medicaid programs and other health insurance programs."

The pharmacy industry pointed out HHS and CMS never mentioned that authority when they announced the program. Moreover, they argued, the authority does not support a program so divorced from current Medicare coverage as a discount card for prescription drugs.

The judge agreed, emphasizing Congress probably did not have such a program in mind when it granted authority to establish an "advisory service program."

The pharmacy groups' second successful argument against implementation of the program was that HHS and CMS did not follow the law requiring advance notice to the public and opportunity for the public to provide input.

The government claimed those requirements were inapplicable, as HHS and CMS were not implementing a new program so much as issuing a general opinion about what kinds of prescrip-

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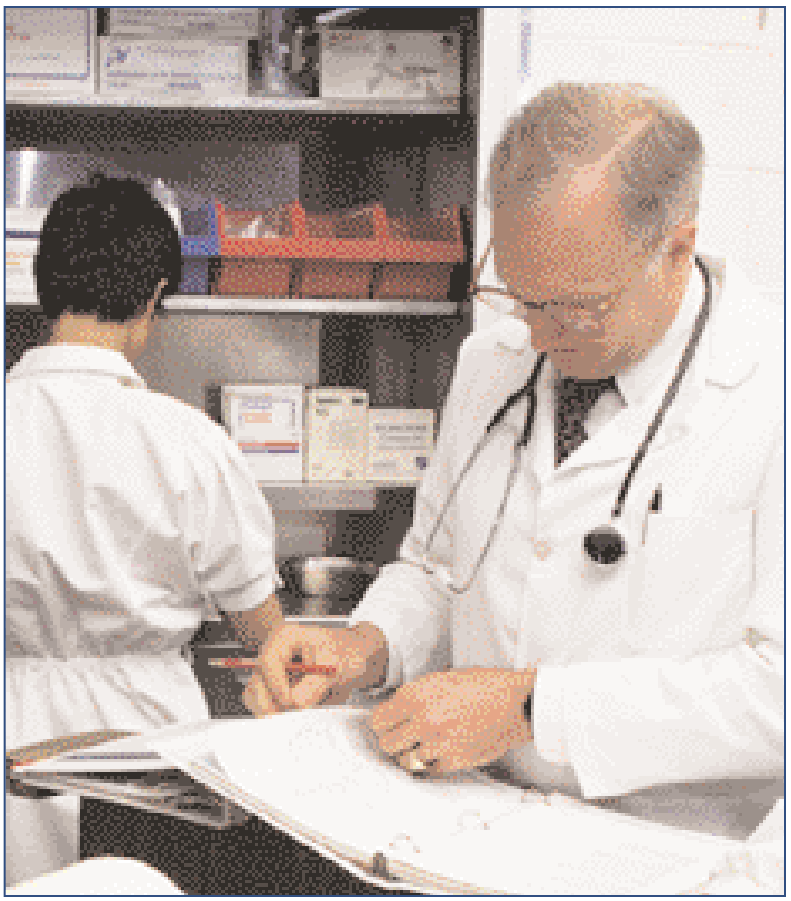

tion drug discount cards it might recommend. The judge ultimately did not buy that argument, emphasizing a program of the expected scale and impact of the prescription drug discount initiative should be subjected to public scrutiny.

What the Future Holds

Although HHS and CMS initially promised to appeal the judge's decision to block the program pending a full trial on the merits, they have instead decided to re-evaluate the program and follow the administrative procedures regarding advance notice and public comment. In doing so, the agencies promised to articulate a legitimate and adequate legal authority for the program that will eventually result from the new process.

In light of that promise, the judge agreed, over the objections of the pharmacy industry, to postpone further proceedings regarding whether the plan could eventually go forward. The Department of Justice, however, has indicated it may still go ahead with its appeal.

Meanwhile, several members of Congress have taken significant interest in the discount card program. Some are working to pass legislation that will provide specific legal authority for the program, while others worked—unsuccessfully—to add to the HHS appropriations bill language prohibiting any use of government funds to implement the program.

Democrats in the House of Representatives have specifically criticized the discount card program. They consider it a poor substitute for a Medicare prescription drug benefit, worry it creates false expectations of savings for seniors, and contend it raises serious fraud and privacy concerns. They have asked the General Accounting Office to investigate and report on those issues.

The litigation over the Medicare Prescription Drug Discount Card Program has been a significant setback for the Bush administration . . . but it has offered some valuable lessons as well.

The litigation has made it clear industry groups will not simply roll over in the ongoing debate over Medicare coverage for prescription drugs. Policymakers must learn to tread carefully in this arena. If they want to achieve a public debate over the *merits* of their proposals, they must first ensure those proposals are beyond reproach in the administrative and procedural details.

"The judge . . . emphasiz[ed] a program of the expected scale and impact of the prescription drug discount initiative should be subjected to public scrutiny."

Demetrios L. Kouzoukas is a lawyer at Gardner, Carton & Douglas and specializes in health law. The views expressed and implied herein are solely those of the author, and they are not to be attributed to Gardner, Carton & Douglas, nor copied or distributed without this disclaimer.

Rethinking a Drug Discount Program

BY DEBI REISSMAN, PHARM.D.

On July 11, 2001, President George W. Bush announced his Medicare Prescription Drug Discount Program. Like many other Americans, I thought this sounded like a good start toward providing seniors with much-needed support for the cost of prescription medications.

A few days later, I began thinking about all the prescription discount card programs currently available through Mature Rx, AARP, *Reader's Digest*, and other organizations, and began wondering why this new program would be any better than what was already available.

Then came the complaints that only PBM [Prescription Benefit Managers] representatives were involved in the development of the concept. And, finally, there were the retail pharmacy lawsuits claiming the administration overstepped its authority in establishing the program. (See related article on page 1, and "Rx Discount Card Plan Stalled by Judge," *Health Care News*, October 2001.)

Negative Consequences

Now that the dust has settled a bit and I have had time to think about this program from all angles, I can't figure out how this program, if implemented, is going to do anything other than raise prescription costs, not just for seniors but for all Americans. In addition, nothing in the program speaks to pharmaceutical care management for a population that is at especially high risk.

Under this program, PBMs would use the pharmacy networks already established for their health plans and/or employer business segments. Since third-party prescriptions, which are heavily discounted, currently comprise 72 percent of all retail prescriptions, increasing this percentage by adding seniors' prescriptions to the network discount rates will cut retailers' already nonexistent margins even further.

Certainly I'm not advocating that senior citizens should pay higher rates and maintain the profit margins of pharmacy retailers so health plans can have lower rates. But, as the percentage of non-discounted business falls, the likelihood is that retailers will renegotiate higher rates for all of their contracted business, affecting the cost of prescription drugs for all parties. Even a $1 per prescription increase will cost the American public more than $2 billion a year in additional prescription costs.

In order to make the discount programs of more value and to entice members to join, PBMs will also have to factor in manufacturer rebates for preferential product use to help reduce costs to seniors. Similar to the story for retailers, manufacturers, while happy to provide discounts on some of their business, will not want to discount all of it.

In order to pass along rebates under the Prescription Drug Discount Program, overall prices will probably have to increase in order to maintain revenues for drug manufacturers. Again, those price increases will affect all prescription drug programs and all Americans.

The senior citizen enrolling in the program may get a discount, but the discount will likely be on a product that now costs more than it cost before implementation of the discount program. If the cost of a pharmaceutical was too great before, how will a discount on a higher-priced pharmaceutical be more affordable?

Many Questions

Finally, there is the issue of pharmaceutical care management.

Providing a discount is only part of the equation. How will this program make sure the enrollee is getting the right dose of the right drug at the right time?

What will be the PBM's responsibility to facilitate the use of B-blockers for persons after a myocardial infarction, angiotensin-converting enzyme inhibitors for persons with congestive heart failure and diabetes, steroid inhalers for persons with asthma, and so on?

Will all programs use the same point-of-care edits and services to assess age-appropriate dosing and drug-drug interactions?

Will PBMs make sure appropriate laboratory work is done, and that dosing is modified as a result of renal or liver impairment?

While drug pricing for each card program will be available for review by the potential enrollee, where will the enrollee find information and assess the quality of pharmaceutical care offered through each of the programs?

Dr. Reissman is president of Rxperts, Inc., a managed care consulting firm in Irvine, California. This article is derived from one that first appeared in Drug Benefit Trends *13(10):23, 2001.* *© 2001 Cliggott Publishing Co., a division of SCP/Cliggott Communications, Inc.*

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Soaring Malpractice Premiums Bleed Doctors, Rob Consumers

Medical Malpractice Payments for Individual Physicians, 2000

STATE	MEDIAN*	TOTAL	RANK
Alabama	$200,000	$34,839,809	24
Alaska	100,000	3,244,459	51
Arizona	150,000	68,920,361	15
Arkansas	91,880	15,220,747	42
California	55,000	200,832,512	7
Colorado	84,997	34,590,151	25
Connecticut	200,000	72,233,556	13
Delaware	150,000	9,324,166	45
Florida**	175,000	321,079,744	3
Georgia	166,667	92,601,367	11
Hawaii	120,000	10,101,623	44
Idaho	100,000	8,553,166	47
Illinois	250,000	271,050,075	4
Indiana**	75,001	59,935,317	17
Iowa	100,000	27,218,617	30
Kansas	175,000	28,867,799	28
Kentucky	75,000	32,651,014	26
Louisiana	99,999	51,362,457	18
Maine	262,482	18,947,319	37
Maryland	150,000	70,318,417	14
Massachusetts	250,000	120,874,822	9
Michigan	85,000	79,040,011	12
Minnesota	100,000	19,099,414	36
Mississippi	127,750	24,560,080	32
Missouri	130,000	48,927,635	20
Montana	125,000	15,805,913	40
Nebraska**	116,250	14,137,915	43
Nevada	175,000	37,090,955	22
New Hampshire	111,000	16,972,268	39
New Jersey	175,000	191,540,088	8
New Mexico**	100,000	20,602,974	34
New York	150,000	632,996,221	1
North Carolina	132,500	68,044,766	16
North Dakota	143,750	4,719,024	49
Ohio	115,000	205,148,823	6
Oklahoma	121,000	28,664,501	29
Oregon	141,500	22,962,782	33
Pennsylvania	192,755	352,309,905	2
Rhode Island	100,000	17,826,074	38
South Carolina**	100,000	29,083,405	27
South Dakota	100,000	5,416,283	48
Tennessee	100,000	35,219,509	23
Texas	110,000	217,518,136	5
Utah	90,000	25,442,649	31
Vermont	75,000	3,318,284	50
Virginia	150,000	45,457,891	21
Washington	90,000	50,356,170	19
Washington, DC	197,500	98,753,106	10
West Virginia	100,000	19,370,928	35
Wisconsin**	162,857	9,309,938	46
Wyoming	100,000	15,650,157	41

* The median amount is the 50th percentile of all the medical malpractice payments made by individual physicians practicing in these states in 2000.

**Mean payments are understated for states with patient compensation funds. The insurer and patient compensation fund payments are treated as separate payments and are not aggregated. For example, a $200,000 primary and $800,000 CAT fund payment for the same incident would be counted as two separate payments and not aggregated as a single million-dollar payment.

Source: Pennsylvania Medical Society

BY VICKI LANKARGE

Skyrocketing medical malpractice insurance premiums are wreaking havoc in communities throughout the United States.

In Beaumont, Texas, for example, the Texas Medical Liability Trust has increased its medical liability rates for all specialists a whopping 120 percent since 1999. It has become so bad in Beaumont that the Texas Medical Liability Insurance Association—the insurer of last resort for doctors with previous malpractice claims against them—is charging individual neurosurgeons upwards of $176,000 a year for a policy that caps malpractice payments at $1 million per occurrence with an overall total cap of $3 million per policy year.

The result? There is only one practicing neurosurgeon left in Beaumont.

"This is a scary thing," says Kim Ross, vice president of the Texas Medical Association. "What if a patient has a car wreck, needs a neurosurgeon, and there's none available? It's an hour to Houston. That 'golden hour' [when treatment is most beneficial] is lost."

It's not any better in Pennsylvania, where 72 percent of doctors polled by the Pennsylvania Medical Society say they have deferred purchasing new equipment or hiring new staff due to sudden, steep increases in their medical malpractice insurance premiums. After absorbing increases between 21 and 60 percent for those premiums in 2001, doctors fear their rates in 2002 could jump another 70 percent.

The society says the hefty sums awarded in malpractice lawsuits are driving doctors' medical liability premiums through the roof. Pennsylvania ranks second among states in terms of total payouts for medical litigation; New York is No. 1. (See accompanying chart.)

"The numbers are off the charts," says Dr. Howard Richter, the Pennsylvania Medical Society's president. "Combined judgments and settlements for fiscal year 2000 amounted to $352 million—roughly $30 per state resident and nearly 10 percent of the U.S. total."

Jump in Jury Awards

Jury awards for medical malpractice claims jumped 76 percent from 1996 to 1999, according to the latest edition of "Current Award Trends in Personal Injury" by Jury Verdict Research.

As a result, many doctors and patient advocates in states that don't have laws to limit the dollar amount of jury awards fear that increasingly large verdicts threaten their health care system by driving up medical malpractice insurance premiums.

To fend off litigation and cope with steep premiums, doctors ultimately are being forced to take defensive measures, such as:

- Practicing defensive medicine by ordering additional, sometimes unnecessary, medical tests. Insurers may be reluctant to pay for them, but doctors want them in order to protect themselves from lawsuits. According to the *Quarterly Journal of Economics*, such "defensive medicine" adds $50 billion per year to the nation's overall health care spending.
- Deferring the hiring of new staff, or even downsizing staff, sparking patient backlogs and making it difficult for patients to get timely appointments.
- Ceasing to practice certain high-risk specialties, such as obstetricians/gynecologists who stop delivering babies because the threat of patient litigation is so high. Richter cites one obstetrics/gynecology group where insurance premiums nearly tripled in 2001 to $1 million. When two of their seven physicians stopped delivering babies, their rates were cut in half.
- Moving their practices to regions with lower medical malpractice insurance costs, or stopping the practice of medicine altogether. Regions with high liability costs may have difficulty attracting new doctors, creating a lack of consumer choice of physicians.

> **"What if a patient has a car wreck, needs a neurosurgeon, and there's none available?"**

Situation Critical in Pennsylvania

Pennsylvania is one state reeling from the effects of the rise in jury awards for medical malpractice claims. Although the state does cap punitive damages, it does not limit "non-economic" jury awards, including damages assessed by juries for "pain and suffering," by far the most common type of jury award.

In 2000, Pennsylvania's doctors and other health care practitioners paid $372 million in total lawsuit judgments, according to research conducted by the state's medical society. That figure ranks second only to New York's approximately $633 million in aggregate medical malpractice lawsuit judgments in 2000.

As a result of Pennsylvania's liability crisis, patients are suffering, according to the Pennsylvania Medical Society. A recent survey of the society's member doctors discovered that more than 90 percent of them are practicing defensive medicine to avoid lawsuits.

There seems to be no limit to the skyrocketing jury awards, says Pennsylvania Medical CAT Fund Director John Reed. "There used to be a gentleman's agreement that lawyers wouldn't go after an award larger than a physician's liability coverage," he says. "Now the gloves are off."

But trial lawyers argue that frivolous lawsuits and large jury awards are not to blame for the health care crisis in Pennsylvania—or any other state.

"Medical error is the 8th largest killer in the United States," says Mark Phenicie, legislative counsel for Pennsylvania Trial Lawyers. "Juries award large medical malpractice settlements in only the most egregious cases. These kinds of lawsuits are not frivolous. If there wasn't a malpractice that happened initially, there wouldn't be a malpractice case or malpractice verdict."

Vicki Lankarge writes for insure.com, the Consumer Insurance Guide.

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The FDA's Victims

The Food and Drug Administration, the federal agency that is supposed to certify the safety and efficacy of pharmaceutical products and medical devices, often drives excellent products off the market. I should know.

BY DR. CHARLES A. HOMSY

I was a manufacturer of medical devices and a victim—along with patients deprived of those devices—of an FDA vendetta.

In the 1960s I invented the material Proplast, which the FDA itself approved for use in implants for patients with distorted, damaged, or destroyed facial structures, jaw joints, thumbs, hips, and other body parts. My company, the Houston-based Vitek, manufactured 30 different Proplast implants that were used successfully in some 100,000 patients—successes documented in more than 125 peer-reviewed publications.

One particular jaw implant was provisionally approved by the FDA in 1983. In 1986, I heard reports about some of these implants wearing out. I convened a conference of surgeons who, in a report to the FDA and the oral surgeons' national association, found fault not with the implants themselves but, rather, with the way some surgeons used them or with the refusal of some patients to follow their treatment plans. But to be on the safe side I stopped promoting the product.

Trial Lawyers on the Prowl

Predatory trial lawyers then got into the act, filing suits against Vitek as well as any company or institute that had anything to do with the device. Most of the lawsuits were summarily dismissed or won by the defendants. But the cost of defense to the Du Pont Company, which supplied Teflon ingredients, was $50 million, and to the hospital where I had invented Proplast, $30 million.

In order to continue to obtain liability insurance, I founded a second company, Novamed, to continue to produce safe Proplast implants that had no record of problems.

But the FDA took its lead from the trial lawyers—indeed, it was a source to them of misinformation about the jaw implant—and turned its legal guns on Novamed and on its FDA-approved products. In various complaints the agency aimed the erroneous charges that had been made against the jaw implant at products about which there were no complaints or investigations whatsoever. These mistakes were pointed out, but the FDA persisted in its persecution.

Eventually it seized the entire stock of FDA-approved Proplast products, and a series of court reversals and re-reversals of that seizure finally forced me in 1992 to shut down Novamed and to team up with a Swiss company to make Proplast products in Europe.

The FDA continued its persecution overseas. It posted the erroneous warnings it had made against the jaw implants against all Proplast products through the World Health Organization. It blocked export from the United States of hip implants needed for technical evaluation and testing.

Still, Canada, Australia, and the EU granted approval for shipments of all Proplast products from Switzerland. Further, when the Swiss company sought approval to export those products to the United States, where they were still legal, and the FDA's own Office of Science and Technology found no problems with the implants, the FDA dragged its heels. The years of costly delays and battles took their toll; the Swiss company declared bankruptcy in 1999.

"The Ultimate Victims"

Who has been harmed by the actions of out-of-control bureaucrats and trial lawyers? Surgeons continue to request Proplast implants and try to secure them for their patients. There is good reason. In many cases adequate alternatives are not available. Many surgeons have returned to the old, more painful, and invasive procedure for jaw joint replacement involving transfer of a rib bone.

Further, to avoid lawsuits or FDA vendettas, many producers of materials required by implant makers discontinued all sales to the implant industry after 1993.

The bottom line: The patients are the ultimate victims. The FDA is not protecting their safety but, rather, increasing their torment.

The Europeans have a better way to approve medical devices. Their governments set out specific, objective quality and safety standards, but then certify private firms to determine compliance to these standards. Manufacturers are allowed to select the company to certify them. The existence of competing companies makes it almost impossible for FDA-type abuses to occur.

The FDA has driven many manufacturers and safe products that relieve pain and suffering from the market. Policy makers wishing to deal with a true health care crisis should stop the damage done by this federal agency.

Dr. Charles A. Homsy, a medical device inventor for nearly four decades, was founder and CEO of both Vitek Inc. and Novamed Inc. He is the author of Cato Policy Analysis *#412, "How FDA Regulation and Injury Litigation Cripple the Medical Device Industry."*

For more information…

WWW The full text of Charles A. Homsy's August 2001 *Cato Policy Analysis*, "How FDA Regulation and Injury Litigation Cripple the Medical Device Industry," is available in Adobe Acrobat's PDF format on the Cato Institute Web site at **http://www.cato.org/pubs/pas/pa412.pdf.**

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PROJECTED ECONOMIC EFFECT Four Universal Health Care Alternatives

Proposal	Loss of Jobs	Loss in Payroll Taxes (billions)	Tax Increase Effect (per capita)	Increase in Personal Income Tax
Medicaid expansion	30,618	$1.274	$78	23%
Pooling the uninsured	61,488	$2.558	$187	46%
Multi-payer system	54,188	$2.255	$127	13%
Single-payer system	117,531	$4.890	$746	233%

Source: Beacon Hill Institute, November 2001

For more information…

WWW For the full text of "Universal Health Care and the Maryland Economy: An Econometric Analysis Using the Maryland State Tax Analysis Modeling Program," released in November 2001, contact Rebecca Moryl, director of operations, Beacon Hill Institute, 8 Ashburton Place, Boston, MA 02108, 617/573-8750. Moryl's email address is rebecca@beaconhill.org.

MARYLAND continued from page 1

posals would decrease employment in the state by between 30,000 and 117,000 jobs, and would require increases in the personal income tax ranging from 13 to 233 percent.

Four Proposals

The study analyzes the economic implications of four proposals for universal health care:

- **Medicaid expansion**, which would move in the direction of universal health care by increasing the number of persons reached by Maryland's existing Medicaid system.
- **Pooling the uninsured**, which would aim for full insurance coverage for all uninsured residents of the Old Line State.
- **A multi-payer system** (some states call it "play or pay"), which would require employers to offer insurance coverage to their employees or pay into a government-created insurance system.
- **A single-payer system**, which would be wholly state-financed and administered and would cover all Marylanders.

Each of the four approaches, note the BHI researchers, would cost the state jobs and payroll and would necessitate an increase in personal income taxes. Expansion of Medicaid is projected to cause the least disruption to the state's economy, while adoption of a single-payer system would be the most disruptive.

"Huge Losses" Inevitable

Single-payer health care has emerged as a major issue in many states. Proponents seek not only to expand health insurance coverage to all citizens, but to achieve cost savings not realized by the current system.

Too often, however, proponents appear not to have considered the cost side of single-payer proposals.

"Whatever the promised benefits of universal health care, it is impossible to throw out the existing health care system in favor of a massive new entitlement without at the same time inflicting huge losses on the economy," warns David G. Tuerck, BHI executive director.

"There is no free lunch," Tuerck adds, "and there is no way to provide universal health care in Maryland without putting many thousands of persons out of work. The euphoria with which its proponents would urge this idea on state policymakers pales in comparison to the economic hardships it would inflict."

The Beacon Hill Institute for Public Policy Research is headquartered at Suffolk University in Boston. It focuses on federal, state, and local economic policies as they affect citizens and businesses. The institute conducts research and educational programs to provide timely, concise, and readable analyses that help voters, policymakers, and opinion leaders understand today's leading public policy issues.

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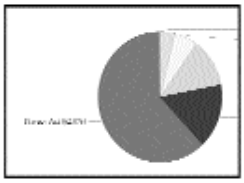

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Insurance Industry Feels 9/11 Pain

Medical Savings Accounts may ease the burden

BY CONRAD F. MEIER

Prior to the September 11 terrorist attacks on New York City and the Pentagon, employers were bracing for a new round of health insurance premium increases. Washington-based Watson Wyatt Worldwide predicted a national average increase of about 14 percent.

Since the attacks, a surge in medical care utilization and the downturning economy have exacerbated employers' health care cost problems, a spokesperson for Watson Wyatt said. Many employers will now face health insurance benefit cost increases in excess of 15 percent in 2002. New York-area employers and employees appear to be hit hardest, with health care costs in the metropolitan region increasing by an additional 3 to 5 percent over previous estimates.

The additional health care cost increases can be attributed to an increase in the use of health care services, mainly mental health services, as well as to a rise in spending on prescription medication to treat anxiety and depression.

> **"Laid-off employees moving to COBRA typically incur costs at least 50 percent greater than active employees . . ."**

Layoffs also affect the cost of health insurance. Claims increase when unemployed workers continue their health care coverage through COBRA. Laid-off employees moving to COBRA typically incur costs at least 50 percent greater than active employees, both during the COBRA extension period and beyond, until they find alternative employer coverage or individual health insurance.

For more information…

WWW see "MSAs Can Be a Windfall for All," by Greg Scandlen, in the December 2001 issue of *Health Care News*.

On the Cato Institute Web site at **http://www.cato.org**, see "Medical Savings Accounts: Progress and Problems under HIPAA," by Victoria Craig Bunce.

Or use The Heartland Institute's free online research service, ***PolicyBot***, to find 49 documents on Medical Savings Accounts. Point your Web browser to **http://www.heartland.org**, click on the ***PolicyBot*** icon, and search for the Topic/Subtopic Health Care/Medical Savings Accounts.

MSA Alternative

Medical Savings Accounts (MSAs) may offer an effective alternative for those losing coverage, and also for the uninsured who seek affordable coverage. Compared to the costs associated with continuing coverage under COBRA rules or switching to traditional individual health insurance, MSAs can be affordable, offering significant savings without sacrificing benefits.

An MSA health plan provides a tax-favored savings account (similar to an IRA) in combination with a high-deductible health insurance policy. The savings account portion accumulates over time from interest earnings and premium payments. The fund is controlled by the insured and can be used to pay routine health care expenses. The second element of the MSA plan, the catastrophic insurance policy, covers the more substantial health care costs incurred by the policy owner or beneficiaries.

While proposals pending in Congress would extend MSA availability, the accounts are currently available only to self-employed individuals or to small-business groups with fewer than 50 employees.

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MSAs Get a Second Look

Consumer control means more affordable health insurance, greater choice, and better value

BY TOM MILLER

Reforming the U.S. health care system is always a matter of evolution, not revolution.

Remember Medical Savings Accounts (MSAs)? For the last five years, they stumbled along slowly in a flawed federal pilot program. Meanwhile, more conventional managed health care practices that relied on top-down controls over access to care hit an unyielding wall of soaring costs, expanded liability risks, political opposition, and consumer discontent.

Second Time Around

Belatedly, MSA-like insurance options that empower individual workers to control more of their own health care are getting a second look by employers.

Congress first launched limited opportunities to open tax-advantaged MSAs as part of the 1996 Health Insurance Portability and Accountability Act (HIPAA). Eligible individuals who purchased qualified catastrophic health insurance coverage also could direct tax-deductible contributions to accompanying savings accounts set up to handle other health care expenses.

The pilot MSAs neither met the ambitious goals of their boosters nor justified the exaggerated fears of their opponents. HIPAA rules restricted eligibility for MSAs to employees of small firms and the self-employed. They imposed unnecessary complexity, created a number of design problems, and discouraged many health insurers from entering the MSA market.

Approximately 100,000 individuals have set up MSA health coverage. At least 25 percent of those were previously uninsured.

Pilot Program Spurs Change

Powerful factors are now at work moving health insurance away from third-party decision-making (by employers, insurers, and government) and toward more consumer-driven alternatives that look quite similar to MSAs. Among the factors driving the new health care environment:

- Health insurance premiums are rising again at annual double-digit percentage rates.
- The managed care backlash has weakened the effectiveness and legitimacy of third-party constraints on health care spending.
- Congress remains poised to use patients' bill of rights legislation to increase employers' health benefits bills by increasing their liability for bad medical outcomes.
- Looser labor markets mean employers will have an easier time attracting employees, even if they offer less-comprehensive insurance coverage and expect greater cost-sharing by employees.
- Wider availability of information technology tools and e-commerce intermediaries is decentralizing health care decision-making.
- Financial services and health benefits products are converging to reshape time horizons for consumption-versus-investment tradeoffs.

Premium Inflation

The sticker shock of rising premiums provides the strongest force for change. Premiums for employer health benefit plans increased an average of 11 percent this year, the largest increase since 1992, according to the Health Research and Educational Trust. Several benefits firms predict further hikes of 12 percent or more next year.

In the short run, employers competing for scarce skilled labor have swallowed higher health care bills and preserved the illusion of comprehensive, prepaid health care "for free." However, the current economic downturn will drive firms to redefine the extent of their obligations to workers—by capping total health benefits contributions, increasing employee cost-sharing, and empowering workers to handle more routine health care decisions.

A defined contribution (DC) health plan offers the best transition vehicle for employers rethinking health benefits strategies. In a pure version, employers simply provide a specified amount of money to employees, who then purchase varying types of health coverage on their own and use remaining funds for other health care spending.

> **"[C]onventional managed health care practices…[have] hit an unyielding wall of soaring costs, expanded liability risks, political opposition, and consumer discontent."**

Lingering Paternalism

A recent Watson Wyatt survey found that only 43 percent of workers are satisfied with the overall performance of their health plan. Less than half (48 percent) trust their employer to design a health plan that will provide the coverage they need. However, most employers remain reluctant simply to finance health benefits without some continuing involvement in structuring employees' choices and monitoring health plan vendors.

Because of the inertia of lingering paternalism, firms are more likely to consider purchasing a "plain vanilla," high-deductible group policy that provides true stop-loss insurance for all their workers, with additional employer contributions to individual spending accounts that subsidize more routine health care needs.

That approach dodges concerns about the effectiveness of individual insurance markets, as well as regulatory complexities and risk adjustment challenges in converting group health plan funding into individualized payments.

Thinking Outside the Box

Last September, Aetna rolled out "HealthFund," the first nationwide health product for mid-sized, self-insured employers that blends the services of a high-deductible, preferred provider health plan and the payment methods of a health savings account. A handful of employers—Aon, Medtronic, Motorola, and others—already have

adopted similar types of defined contribution plans that combine high-deductible coverage with individual accounts.

More employers should step up and empower workers to make their own decisions and bear more responsibility. If the extra cost of more generous coverage or additional health spending was paid directly by employees, they would compare the value of the care they receive to other goods and services they might want.

Setting defined contribution payment limits also could help employers better manage their health care costs and dodge the crossfire over health plan regulation and benefits mandates.

Several public policy reforms could accelerate the transition to consumer-driven health care: allow tax-free annual rollovers of funds in individual health savings accounts, remove remaining barriers to universal MSAs, and provide a tax credit option for working families.

Whether we call the new health financing options MSAs, DCs, or some other acronym, they all spell out more affordable health insurance, greater choice, and better value.

Tom Miller is director of health policy studies at the Cato Institute and contributing editor to Health Care News. *His email address is tmiller@cato.org.*

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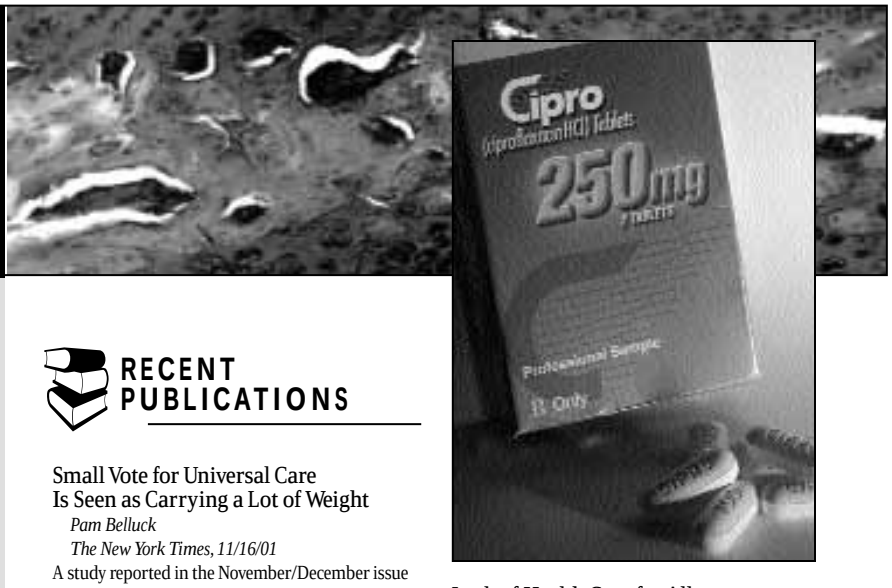
THE GALEN REPORT

A monthly review of health policy matters



Those anticipating the next generation of miracle medicines should be appalled by the results of the World Trade Organization meeting in Doha last November.

Activists won a "victory" in allowing poor nations to seize patents on drugs for everything from AIDS to asthma. While the pharmaceutical industry says legal protections for their patents still exist, the overwhelming perception is that intellectual property rights have suffered a severe blow.

Over and over, the activists reminded WTO representatives that U.S. Health and Human Services Secretary Tommy Thompson threatened to violate Bayer's patent for Cipro if the company didn't agree to cut the price. If the U.S. can do it, why can't we? the activists argued.

The Wall Street Journal names the drug industry as the loser in the negotiations, but the real losers are the patients whose illnesses and diseases could be cured by medicines they may never see because companies fear their investments of hundreds of millions of dollars could be stolen with little or no defense by the U.S. government.

Prescription Drug Security

Domestically, key members of the American Legislative Exchange Council (ALEC) have been working hard to turn The Galen Institute's Prescription Drug Security Card idea into model legislation for the states.

ALEC's Prescription Drug Working Group met in Austin last November, under the leadership of Senator Steve Newman of Virginia with staff assistance from Jennifer King of ALEC. I traveled to Austin to provide advice, and several of us worked until midnight to reshape and improve the plan.

"[T]he real losers are the patients whose illnesses and diseases could be cured by medicines they may never see because companies fear their investments… could be stolen with little or no defense by the U.S. government."

From the seed of an idea to provide a market-based prescription drug benefit to low-income seniors, it is evolving into a detailed plan, largely as a result of excellent ideas and input from a number of experts.

Our version of the PDS plan would provide an upfront sum of $600 a year to help seniors with routine drug purchases, then would provide private catastrophic coverage for large bills. The government would pay all or part of the premium for low-income seniors, but others could participate in the plan as well. Seniors not only would get help with routine drug purchases and be protected from large drug bills, but also would most likely join a plan offering discounts and drug consultation.

Grace Marie-Turner

RECENT PUBLICATIONS

Small Vote for Universal Care Is Seen as Carrying a Lot of Weight

Pam Belluck
The New York Times, 11/16/01

A study reported in the November/December issue of *Health Affairs* ("Americans' Health Priorities Revisited After September 11," Blendon *et al.*) found that Americans see health care as a much lower national priority than they did before the attacks of September 11.

But while Americans may now be more concerned about terrorism and national defense, an article in the November 16 edition of *The New York Times* about the nonbinding resolution to universalize health care in Maine illustrates this is not a time to lose focus in the fight for free-market health care reform. Pam Belluck reports the passage of the proposal in Portland "reawakened interest in universal health care, and, more important, the amount spent to defeat it shows how seriously the health care industry is taking the new movement."

http://www.nytimes.com/2001/11/16/national/16MAIN.html
http://www.healthaffairs.org

Bioterrorism and Pharmaceuticals: The Influence of Secretary Thompson's Cipro Negotiations

John E. Calfee
American Enterprise Institute, 11/1/2001

"The stakes in the Cipro patent abridgement threat are enormous," Calfee writes. He quotes Thompson's congressional testimony last month under questioning by Rep. Bernie Sanders: Sanders: "But you are prepared, if Bayer does not cooperate with you, to [go to generic companies]?" Thompson: "Yes, I am."

"This dispute is not just about Cipro and Bayer; it is about what the research industry can expect our government to do in the future. Who is going to do the research necessary to create a really good anthrax or smallpox vaccine, or create a way to bring new treatments for anthrax or the plague to market as soon as a new strain appears—if they think that when the research is done and manufacturing is underway, Congress or HHS may exercise its right to open the market up to generic manufacturers?" Calfee asks.

"Secretary Thompson and HHS should immediately issue a definitive statement saying that they did not ever actually intend to abridge Bayer's Cipro patent, and would not do so if they again faced even remotely similar situations. They should urge other nations to make similar declarations," Calfee concludes.

http://www.aei.org/ps/pscalf011101.htm

Lack of Health Care for All Creates U.S. Security Risk

Ted Halstead and Michael Lind
USA Today, 11/12/2001

In an opinion article in *USA Today*, Ted Halstead and Michael Lind warn the uninsured can pose a security risk to all Americans.

Americans without insurance are less likely to seek treatment and could therefore unknowingly aid the spread of biological agents. Halstead and Lind argue "[t]he nature of America's new war on terrorism suggests two guiding principles: Universal insurance should be citizen-based, not employer-based. And a single-payer funding method should be avoided because it would be too expensive during this period of military buildup and economic weakness."

In a time where average job tenure is three to five years and layoffs abound, "a better approach" would be to require all Americans to purchase their own insurance and subsidize coverage for those who are "too poor or sick to pay for coverage."

http://www.usatoday.com
(payment for the article is required)

Canada's Abysmal Health Technology Record

Nadeem Esmail
Fraser Forum, 11/2001

Per-capita, Canada ranks fifth among OECD countries on health care spending, but it has "relatively few health technologies available for Canadians," says Nadeem Esmail of The Fraser Institute. Esmail says important diagnostic equipment, including MRI machines and CT scanners, is scarce in Canada as compared to technology available to citizens of other wealthy countries, including the U.S.

Despite Canada's high spending per person, the country ranks 19th in the number of MRIs and 18th in CT scanners, significantly behind the United States. As a result, Canadians suffer long waits to receive advanced diagnostic testing.

http://www.fraserinstitute.ca/publications/forum/2001/11/section_12.html

The Galen Report *is a monthly review of health policy matters provided by The Galen Institute, P.O. Box 19080, Alexandria, VA 22320, Web site http://www.galen.org. Grace Marie-Turner is president. This report is compiled by editor Elizabeth Lamirand, who can be contacted at 703/299-9550.*

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Canada Saves Little with Generic Drugs

BY JOHN R. GRAHAM

Recently, a report on the cost savings of generic drugs made front-page news in Canadian newspapers.

Malcolm Anderson and Karen Parent of Queen's University analyzed prices of 34 generic drugs introduced in Canada between 1995 and 1999. They concluded provincial drug benefit plans could have saved about $34 million if these drugs had been put on their formularies (lists of subsidized drugs) six months earlier than they were.

A new, innovative drug is usually invented by a multinational, brand-name pharmaceutical company. Governments recognize and protect this intellectual property by granting patents, which prevent competitors from copying the product for a specified time, usually 20 years.

After the original drug's patents expire, other manufacturers are free to sell copies of the drug, subject to regulatory approval by Health Canada. These generic drugs are cheaper than the original, because the generic manufacturer has not made the research and development investment that the original, brand-name manufacturer has.

Generics Offer Some Savings

Anderson and Parent examine two bottlenecks that delay access to generic drugs: Health Canada, which judges whether the generic drug is effectively the same ("bioequivalent") as the original drug; and the time it takes for approved generic drugs to get listed for reimbursement by provincial drug benefit plans.

Unfortunately, the savings promoted are quite insignificant as a proportion of subsidized prescription drug costs. During the five years examined, governments in Canada spent over $18 billion on their drug benefit programs. Savings of $34 million would have reduced that figure by about one-fifth of 1 percent.

Anderson and Parent examined 34 of the estimated 120 generic drugs introduced during the period. Although the authors claim their calculation is conservative because they do not extrapolate estimated savings from quicker approvals for the entire 120, they do not state how they selected the 34 drugs, nor whether they think price differences between these generic drugs and their branded competitors are greater or less than they are for the other 86 drugs.

If one assumes the sampled drugs are representative of all generic drugs introduced over the period, and estimates savings gained by speeding up the listing of all 120 drugs by six months, the resulting savings of $129 million are still less than three-quarters of 1 percent of governments' prescription drug costs over the period.

> **"The resulting savings of $129 million are still less than three-quarters of 1 percent of governments' prescription drug costs over the period."**

Although quicker approval and reimbursement of generic drugs is unlikely to result in meaningful savings, there is another way provincial drug benefit plans might increase savings through generic drugs.

Generics Expensive in Canada

Many generic drugs are priced even higher in Canada than they are in the U.S. Using data from 1994-1995, Anderson and Parent note Ontario reimbursed generic drugs at prices between 61 percent and 79 percent of the brand-name price, while a private insurer paid between 45 percent and 67 percent of the brand-name price. Generally, if there was only one generic copy of a drug, the discount was smaller, but if there were many generic copies, the discount was larger. Unfortunately, competition among generics was generally weak.

Of the 260 generic compounds on the Ontario formulary that were surveyed, 154 (59 percent) had only one or two generic versions. Anderson and Parent also note that about 42 percent of Ontario's prescriptions in 1998 were for generic drugs.

Assuming those prescriptions were filled at 75 percent of the brand-name price, Ontario would have spent 2/3 of its drug budget on branded drugs and 1/3 on generics. That is, of 1998 expenditures of about $1.6 billion, the branded share would have been just over $1 billion and the generic share just under $600 million.

Provinces could have saved money by paying the same generic prices as negotiated by private insurers. For example, if Ontario had lowered the price of generic drugs to 65 percent of the brand-name price, the savings (assuming no increase in volume) would have been $74 million in that year alone—almost 5 percent of that year's prescription drug expenditures.

Since the period studied by Anderson and Parent, Ontario has negotiated small reductions in generic prices. However, this is just a beginning. The private insurer paid 45 percent of branded drug prices for those compounds where there were five generic competitors. If Ontario had received this discount for all generics, the province would have reduced costs in 1998 by $222 million, 14 percent of the annual budget!

Recommendations Off-Target

Anderson and Parent's analysis thus leads to quite different policy implications than those they develop. They recommend finding ways to reduce lengthy regulatory approval and delays in provincial reimbursement of generic drugs. But those factors are trivial in the battle to contain provincial drug costs.

The real priorities must be to increase the level of competition in the generic sector and to get prices comparable to those negotiated by private health insurers, perhaps by outsourcing the program to those insurers.

John R. Graham is senior analyst and acting director of the Pharmaceutical Policy Research Centre at the Fraser Institute. He has written a series of papers on pharmaceutical pricing. His email address is at johng@fraserinstitute.ca.

For more information…

WWW The August 2001 report by Malcolm Anderson and Karen Parent, *Timely Access to Generic Drugs: Issues for Health Policy in Canada*, was published by Queen's University. The full text is available on the Web site of the Canadian Drug Manufacturers Association at **http://www.cdmaacfpp.org/issues/pr_on_06.shtml**.

John R. Graham's series on prescription drug prices is available on the Web site of the Fraser Institute. "Prescription Drug Prices in Canada and the United States" can be found at **www.fraserinstitute.com.**

TennCare Reform Moves Ahead

BY CONRAD F. MEIER

Starting last December, Tennessee officials were allowed to begin removing ineligible enrollees from TennCare, the state's troubled Medicaid managed care program, under a compromise agreement reached in federal district court.

After two days of negotiations between the state and the Tennessee Justice Center, which is representing TennCare enrollees, U.S. District Judge William Haynes approved a "reverification" plan that will allow the state to begin sending enrollment termination notices that outline "appeal rights" to 52,000 people already deemed ineligible, and eventually to all 600,000 Medicaid-ineligible enrollees.

Under the agreement, termination notices will be sent to enrollees who have not paid their premiums for the past four months, unless they have one of two specific mental conditions. Those conditions were not revealed.

State officials have identified 25,000 TennCare beneficiaries with "invalid addresses" and another 27,000 who have failed to pay their TennCare premiums for at least four months. Rather than being dropped from the program immediately, enrollees will have 30 days to contact the state and begin paying premiums—missed payments may be made up over a 10-month period.

TennCare will also begin consulting with other state agencies and managed care organizations to "identify the whereabouts" of enrollees with invalid addresses. Once enrollees are located, termination notices, which explain the appeals process, will be sent to them.

TennCare spokesperson Lola Potter explained the reverification process will then expand to the entire TennCare population. At first, the state projects it will complete 8,000 to 10,000 verifications per month, but eventually hopes to reverify 40,000 to 60,000 enrollees a month.

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My Turn

The Sound of the Other Shoe Falling

For more information…

WWW on the Clinton health care task-force files, see **http://aapsonline.org/judicial/aapsvsclinton.htm** and the University of Maryland at **http://www.umd.edu**—search National Archives No. 2.

CONRAD F. MEIER
MANAGING EDITOR

The Clinton administration's plan for universal health care never was about "the greater social good" or "doing the people's business."

It was about elimination of the private insurance sector—from the corporate boardroom to the insurance broker in the field. All would be eliminated in favor of one insurance agent . . . the government. The ill-fated Clinton proposal was a plan for compulsory enrollment, compulsory health insurance taxes paid by employers, increased public taxation, and means-tested premiums.

It was about the elimination of private medical care—from the doctor's office to the drug store. Every health care move you made—from your doctor's appointment to your mastectomy to your Viagra purchase—would be under government control and recorded in a government databank.

The Real Story Emerges

There are millions of records describing the secret workings of Hillary Clinton and her health care task force, thanks to Judge Lamberth's order making them public back in March 1993. In a lawsuit filed by the Association of American Physicians and Surgeons, Lamberth found Mrs. Clinton and the top-tier of 12 select advisors had blatantly violated "open meeting laws."

From many internal memos, it appears both Clintons, and their confidants Ira Magaziner, Vincent Navarro, and James Carvil, knew early on that Congress would never pass the enabling legislation needed to nationalize the health care system in one traumatic step.

While the plan of choice was to create a single-payer health care system, they expected all along that it would be the fall-back plans that would make their way through a Republican Congress and become the law of the land.

Fallback 1: Kids in Co-ops

In August 1992, task-force memos show Mrs. Clinton's advisors took great interest in "KiddieCare," a part of the Great Society LBJ never had a chance to propel through Congress in 1968. Task-force members requested reams of documents from the LBJ library in Austin. Eventually, those documents became part of the task-force record and formed the foundation for a new plan to bring all uninsured children and uninsured mothers under a national health insurance system administered by the Medicaid bureaucracy.

> **"This is not about doing the 'greater social good,' or any other warm and fuzzy sound bite. This is about socialized medicine, plain and simple . . . and dangerous."**

There is further evidence in a key follow-up memo seven months later, dated March 24, 1993, from White House advisor Atoll Gwande to task-force member and Minnesota health commissioner Lois Quam. The memo clearly states the Clinton health care plan would focus on children, using them to bring about socialized medicine in what was first described as "Kids in Cooperatives."

Single-Payer by Default

We now recognize the agenda as "KidCare" or SCHIP (States Children's Health Insurance Plan). SCHIP has rapidly exceeded its publicized intent of providing Medicaid health insurance to uninsured children. In many states, SCHIP coverage now extends from birth to age 21, employing school-based health care clinics called for in "Healthy Goals 2000."

Medicaid waivers have been granted to states allowing expansion of SCHIP plans to uninsured mothers and uninsured parents of the children eligible for KidCare. In some states, the family income means-test has been increased to three times the federal poverty level ($14,630). In other words, taxpayers are, in some states, paying to insure three-person households with annual incomes as high as $43,890.

Most Americans think Medicaid is a health insurance program for the poor. In fact, it's being made into a single-payer health care system by default through creative interpretation, manipulation of original intentions, and the stealth use of taxpayer funds.

While reforms may have cut *welfare* rolls dramatically, the *health care* welfare rolls have grown dramatically over the past several years.

Fallback 2: HIPAA

There is a great deal of evidence to support the conclusion that enabling legislation for the Health Insurance Portability and Accountability Act (HIPAA) is built on the Health Security Act first proposed by the Clint task force. All they needed was someone to lay the proposal in front of Congress.

The Clinton administration called on national health care stalwart Senator Ted Kennedy (D-Massachusetts), who in turn called on a naive and retiring Kansas Republican, Senator Nancy Kassebaum.

The Kassebaum-Kennedy bill became HIPAA legislation, and it was everything Kennedy and the Clintons needed to continue their slow, methodical progression toward a single-payer health care plan. It became considerably more than what Kassebaum ever imagined or wanted. Even Bob Dole admitted as much.

HIPAA contains the keys for a national single-payer plan: It takes authority over regulatory functions previously in the domain of states; nationalizes such insurance mandates as guaranteed issue and guaranteed renewal; mandates a national medical database; and incorporates language enabling and authorizing creation of a national citizens identification system.

Reform Deja Vu

During the 2002 state legislative sessions, health care reformers across the country should be prepared to defend free markets and individual liberty. Socialized health care advocates in Colorado, Maine, Maryland, Missouri, and Washington are hoping to convince voters and legislators that Mrs. Clinton should get a second chance at socializing American health care—even if it means doing it one state at a time.

This is not about doing the "greater social good," or any other warm and fuzzy sound bite. This is about socialized medicine, plain and simple . . . and dangerous.

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___ BUSINESS
_____ For-profit company
_____ Non-profit company
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Return by Mail to: The Heartland Institute, 19 S. LaSalle Suite 903, Chicago, IL 60603 or fax this entire form to 312.377.5000

The information you have provided will be kept strictly confidential. The Heartland Institute from time to time offers its mailing list to organizations whose goals are similar to ours. If you prefer not to be contacted by such groups, please check here._____

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